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ABSTRACT

This mini-course for nurses is intended to establish an atmosphere conducive to the development of personal awareness of the ramifications of alcohol/substance abuse involving the nurse. Contents include the mini-course's goals and objectives, a course outline, copies of 11 handouts and a booklet written to provide information about nurse impairment due to alcohol and/or drugs, and the pretest/posttest. The curriculum section, after providing historical perspective in an introduction, deals with the following topics: classifications of commonly abused drugs, alcoholic substances, vocabulary/terminology, proposed causes of nurse impairment, commonly abused drugs in the nursing profession and signs and symptoms/behavior, prevention of nurse impairment, intervention, and legal and ethical implications. End notes, a list of references, and a selected bibliography are also provided. (YLB)

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THE IMPAIRED NURSE

This project is the result of Grant SCDG 404.

Participants: Mrs. Linda Stahl, R.N., B.S., Project Director
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The projects contained herein were conducted pursuant to contracts from the New Jersey State Department of Education, Division of Vocational Education and Career Preparation. They were funded under Sections 131, 132, 133, 134, 135, 136 and 123 of Public Law 94-482. The contractors undertaking the projects were encouraged to express fully their judgements in professional and technical matters. Points of view or opinions do not, therefore, necessarily represent official New Jersey State Department positions or policies.

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IDENTIFICATION NO. SCDG 404 AMOUNT FUNDED 3450

FUNDED UNDER SECTION _____ OF P.L. 94-482

PROJECT TITLE: "The Impaired Nurse" Development of Curriculum and Related Teaching Materials

LEGAL NAME OF APPLICANT DISTRICT, INSTITUTION OR AGENCY: Morris County Vocational School District

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ABSTRACT

DESCRIPTION OF PROJECT

(Use this sheet and no more than one other to type in single-spaced form a statement of project objectives, procedures that were followed, state and local priorities emphasized and the expected contribution of the project to vocational education.)

The problem of alcohol/drug abuse in all levels of nursing is a growing concern. Because it is often work related and involves actual misuse of patients' medications, its ramifications go beyond those of substance abuse in other fields of employment. The predisposition to substance abuse often begins in nursing school and, statistically, the nurse most likely to become involved in substance abuse is 25-31 years old and had been in the top third of his/her nursing class.

A recent Board of Nursing survey shows that no nursing school in New Jersey offers a curriculum specific for the Impaired Nurse. The survey also reports that few nursing schools offer comprehensive curriculum on drug/alcohol abuse.

It is proposed that curriculum for a mini-course on the Impaired Nurse be developed. In addition to curriculum, it is further proposed that the following products also be prepared for dissemination to the LPN vocational programs and to the New Jersey Board of Nursing:

1. A list of strategies for integrating information about the Impaired Nurse into existing units of LPN curriculum.
2. A bibliography of texts, resource materials and teaching for further research and education of both instructors and students.
3. A listing by counties of agencies which offer assistance to the Impaired Nurse.
4. A self-help booklet directed to the student nurse which lists warning signs and procedures to follow when seeking help and other pertinent information.

Abstract (Description of Project)

All projects will be completed after the normal workday by the participant and the project director according to timelines pre-established.

The New Jersey Board of Nursing has recently established a Committee on the Impaired Nurse, as have 13 other states. None have developed curriculum. None have addressed the problem in the nursing schools. At least sixteen state-level licensing agencies have asked New Jersey for input into the development of materials for use in the nursing schools in New Jersey. The problem of the Impaired Nurse may be addressed before it actually happens. The dissemination of information will act as a prevention.

GOALS AND OBJECTIVES FOR MINI-COURSE

"THE IMPAIRED NURSE"

The goal of the mini-course is to establish an atmosphere conducive to the development of a personal awareness of the ramifications of alcohol/substance abuse involving the nurse.

Following attendance of and participation in the course, the student will be able to:

1. Distinguish among the various classifications of drugs most commonly abused.

2. Recall specific facts regarding alcoholic substances.

3. Correctly use the appropriate terminology and vocabulary of the unit.

4. Discuss biomedical processes and consequences of alcohol and substance abuse.

5. Analyze one's own personal and professional life style to determine likelihood of predisposition to substance and alcohol abuse.

6. Draw conclusions regarding the constructive handling of life's occupational stresses.

7. Distinguish various forms of support available to self or colleagues in the event of impairment.

9. Evaluate changes in job performance which may indicate impairment.

10. Discuss codes of ethical standards and legal ramifications of behavior.

11. Judge the effectiveness of the course through written evaluations.

COURSE OUTLINE

"THE IMPAIRED NURSE"

I. Pre-test

II. Introduction

III. Classifications of Commonly Abused Drugs

A. Central Nervous System Depressants
B. Central Nervous System Stimulants
C. Psychedelics
D. Volatile Hydrocarbon Anesthetics
E. Opiates

Handouts: 1. Glossary of Street Terms
2. Controlled Substances: Uses & Effects

IV. Alcoholic Substances

A. General Review
B. Alcoholic Content of Beers vs. Wines vs. Spirits
C. Blood Levels

Film: "Pathophysiology of Alcohol Abuse"

V. Vocabulary/Terminology

A. Addiction
B. Tolerance
C. Physical/Psychological Dependence
D. Addiction vs. Habituation: Drug Dependence
E. Alcoholism
F. Withdrawal (Abstinence Syndrome)

VI. Proposed Causes of Nurse Impairment

A. Shift Work
B. Burnout
C. Other Predisposing Factors

1. Personal Role Adjustments
2. Professional Role Adjustments
3. The High Risk Personality/Statistics

D. Availability of Drugs

1. Employment Situation
2. Diversion of Medications/Falsifying Records

E. Risk Factors in Personal or Family Background

VII. Commonly Abused Drugs in the Nursing Profession/Signs and Symptoms/Behavior

A. Narcotics
B. Non-Narcotic Depressants
C. Stimulants

Film: "Sex, Booze, Blues and the Pills You Use"
Handout: 3. Indicators of Nurse Impairment

VIII. Prevention of Nurse Impairment

A. Joint Effort

1. The Professions Responsibility
2. The Health Care Institute
3. The Nurse

B. Safeguards and Procedures for Regulating Narcotics
C. Other Strategies
D. Recognition of Stress

Film: "The Family Trap"
Handouts: 4. Institutional Strategies
5. Self-Care Strategies
6. Packet of Worksheets on STRESS
7. Family Trap Characteristics

IX. Intervention

A. Recognition of the Problem (Review)

1. Job Performance
2. Non-Specific Changes
3. Alcoholism Clues
4. Drug Addiction Clues

B. Intervention Plan

1. Acute Phase Intervention
2. Chronic Behavior Intervention

C. A List of DONT'S
D. Employee Assistance Programs
E. Community Resources

Handouts: 8. A List of Don'ts
9. Help for the Helper: An Employee Assistance Program
10. Comprehensive List of N. J. Treatment Centers

X. Legal/Ethical Implications

A. Loss of License/Penalties
B. Loss of Employment

Handout: 11. N.J. Board of Nursing Disciplinary List

XI. Summation

XII. Post Test

GLOSSARY OF TERMS

ACAPULCO GOLD	Any superior quality Marijuana
ACID	Usually refers to LSD, but can by any Psychedelic
AMES	Amyl Nitrite
ANGEL DUST	Phencyclidine (PCP)
BAG	Small package of illegal drugs
BLACK BEAUTIES	Biphetamine; other black capsules
BLOTTER, BLOTTER ACID	LSD on porous paper
BUMMER, BUMMED OUT	Replacing "Bad Trip" in describing an intensely negative emotional and/or phychological experience; specifically an adverse reaction to a psychedelic
BUSH	Marijuana
BUTTONS	Peyote slices containing mescaline as primary active alkaloid
CAP	Capsule
CIBAs	Glutethimide
COKE	Cocaine
CONNECTION(s)	Access to important persons, usually dealers
CRASH	"Coming down," usually after an intense and/or lengthy experience with stimulants or psychedelics; also, refers to falling asleep normally
CRYSTAL, CRYSTAL METH	Methamphetamine, usually from illicit manufacturing source
DEX, DEXIES	Dextroamphetamine, all forms
DO, DO UP	Take a drug (as in "want to do some dope?")
DOLLIES	A brand of methadone HCL

DOPE	Any drug
DOUBLE DOME	Tablets, usually LSD
DOWN, DOWNS, DOWNER	Any sedative drug
F-40's	Secobarbital
FIX	Inject
FLASH, FLASHED, FLASHED ON	A "rush" (see below) of short duration, sometimes experienced repetitively; also can refer to an immediate, empathetic understanding or enjoyment or a person, place, or thing
FREAK, FREAKS (noun)	A term of endearment among members of those subcultures which value societal differences, commonly used as an ironic comment on social status (as in "token freak"); any "weird" person (see below)
FREAK, FREAKED (verb)	Sometimes used with "out" to described either good or bad feelings (as in "I was really freaked when they...")
GET DOWN	Use Heroin
HASH	Hashish
HEP	Hepatitis
HIPPIE	Another term of endearment among various subcultures, also used ironically (as in one longhair to another "you damn hippie").
JOINT	Marijuana cigarettes; Jail
JUICE	Any alcoholic beverage; also, "connections."
JUNK	Heroin, now rarely used
KE	Kilo; 2.2 pounds of Marijuana
KIT	Hypodermic equipment
LID	Approximately I oz. of Marijuana
MESC	Mescaline
METH	Methamphetamine

MICRODOT	Tiny tablet LSD
O.D.	Overdose
PANAMA RED	Any superior grade of Marijuana
POT	Marijuana
PRIMO	Very good drug, usually Marijuana
REDS	Generally secobarbital, but can refer to any drug in a red capsule
RIG	Hypodermic equipment
ROACH, ROACH CLIP	End of joint; clip to hold it
RUSH	Any intense physical or emotional experience of abrupt onset, usually pleasant, frequently after ingesting or injecting a drug
SCAG	Heroin
SEEDS	Usually morning glory seeds; can refer to Marijuana seeds
SHOOT	Usually inject
SMACK	Heroin
SMOKE	Marijuana, rarely, refers to smokable opium drugs
SNORT	Inhale a drug in powder form via the nose
SOPORS (tm)	Usually methaqualone, but can refer to any mild sedative drug
SPEED	Any stimulant drugs; specifically, Methamphetamine
STRUNG OUT	Adverse status vis-a-vis drug experiences, usually indicating a high level of use of a drug; includes some concept of dependency with negative sequellae
STUFF	Usually heroin, but can refer to any drug
SUNSHINE	LSD as an orange tablet

THC	Refers to any drug sold as tetrahydrocannabinol; rarely available on the street, "THC" is usually LSD or PCP
UPS, UPPERS	Any stimulant drug
WEED	Marijuana
WEIRD	Descriptive of any person, place, or thing which varies from some, usually indeterminate, norm; also can connote a positive relationship to that person, place, or thing
WHITE CROSS	Popular form of Methamphetamine; illicitly manufactured white tablet of poor friability, x-scored, containing approximately 15-20 mg. Methamphetamine
WINDOW PANE	LSD in small squares of coated plastic or stiffened gel
WIRED	Highly stimulated, usually under the influence of a stimulant drug
WORKS	Hypodermic equipment

Source: Oss, James N., et al, Clinical Management of Druge Abuse Crisis: A Reference Manual for Health Professionals; Hoffman-LaRoche, Inc., 1973

Controlled Substances: **uses and effects**

Drugs	Schedule*	Often Prescribed Brand Names	Medical Uses	Dependence Potential: Physical	Dependence Potential: Psychological	Tolerance	Duration of Effects (in hours)	Usual Methods of Administration	Possible Effects	Effects of Overdose	Withdrawal Syndrome
Opium	II	Dover's Powder, Paregoric	Analgesic,antidiarrheal	High	High	Yes	3 to 6	Oral, smoked	Euphoria, drowsiness,respiratory depression, constricted pupils, nausea	Slow and shallow breathing, clammy skin, convulsions, coma, possible death	Watery eyes, runny nose, yawning, loss of appetite. Irritability, tremors, panic, chills and sweating, cramps, nausea
Morphine	II	Morphine	Analgesic	High	High	Yes	3 to 6	Injected, smoked			
Codeine	II III V	Codeine	Analgesic, antitussive	Moderate	Moderate	Yes	3 to 6	Oral, injected			
Heroin	I	None	None	High	High	Yes	3 to 6	Injected, sniffed			
Meperidine (Pethidine)	II	Demerol, Pethadol	Analgesic	High	High	Yes	3 to 6	Oral, injected			
Methadone	II	Dolophine, Methadone, Methadose	Analgesic, heroin substitute	High	High	Yes	12 to 24	Oral, injected			
Other Narcotics	I II III V	Dilaudid, Leritine, Numorphan, Percodan	Analgesic,antidiarrheal antitussive	High	High	Yes	3 to 6	Oral, injected			
Chloral Hydrate	IV	Noctec, Somnos	Hypnotic	Moderate	Moderate	Probable	5 to 8	Oral	Slurred speech, disorientation, drunken behavior without odor of alcohol	Shallow respiration, cold and clammy skin, dilated pupils, weak and rapid pulse, coma, possible death	Anxiety, insomnia, tremors, delirium, convulsions, possible death
Barbiturates	II III IV	Amytal, Butisol, Nembutal, Phenobarbital,Seconal,Tuinal	Anesthetic,anti-convulsant, sedation, sleep	High	High	Yes	1 to 16	Oral, injected			
Glutethimide	III	Doriden	Sedation, sleep	High	High	Yes	4 to 8	Oral			
Methaqualone	II	Optimil,Parest,Quaalude, Somnafac, Sopor	Sedation, sleep	High	High	Yes	4 to 8	Oral			
Tranquilizers	IV	Equanil, Librium, Miltown Serax, Tranxene, Valium	Anti-anxiety, muscle relaxant, sedation	Moderate	Moderate	Yes	4 to 8	Oral			
Other Depressants	III IV	Clonopin,Dalmane,Dormate, Noludar,Placydil,Valmid	Anti-anxiety, sedation, sleep	Possible	Possible	Yes	4 to 8	Oral			
Cocaine**	II	Cocaine	Local anesthetic	Possible	High	Yes	2	Injected, sniffed	Increased alertness, excitation, euphoria,dilated pupils, increased pulse rate and blood pressure, insomnia, loss of appetite	Agitation, increase in body temperature, hallucination, convulsions, possible death	Apathy, long periods of sleep, irritability,depression, disorientation
Amphetamines	II III	Benzedrine, Biphetamine, Desoxyn, Dexedrine	Hyperkinesis, narcolepsy, weight control	Possible	High	Yes	2 to 4	Oral, injected			
Phenmetrazine	II	Preludin	Weight control	Possible	High	Yes	2 to 4	Oral			
Methylphenidate	II	Ritalin	Hyperkinesis	Possible	High	Yes	2 to 4	Oral			
Other Stimulants	III IV	Bacarate, Cylert, Didrex, Ionamin, Plegine, Pondimin, Pre-Sate, Sanorex, Voranil	Weight control	Possible	Possible	Yes	2 to 4	Oral			
LSD	I	None	None	None	Degree Unknown	Yes	Variable	Oral	Illusions and hallucinations (with exception of MDA); poor perception of time and distance	Longer, more intense "trip" episodes, psychosis, possible death	Withdrawal syndrome not reported
Mescaline	I	None	None	None	Degree Unknown	Yes	Variable	Oral,injected			
Psilocybin-Psilocyn	I	None	None	None	Degree Unknown	Yes	Variable	Oral			
MDA	I	None	None	None	Degree Unknown	Yes	Variable	Oral,injected,sniffed			
PCP***	III	Sernylan	Veterinary anesthetic	None	Degree Unknown	Yes	Variable	Oral,injected,smoked			
Other Hallucinogens	I	None	None	None	Degree Unknown	Yes	Variable	Oral,injected,sniffed			
Marihuana Hashish Hashish Oil	I	None	None	Degree Unknown	Moderate	Yes	2 to 4	Oral, smoked	Euphoria, relaxed inhibitions increased appetite,disoriented behavior	Fatigue, paranoia, possible psychosis	Insomnia,hyperactivity & decreased appetite reported in some individuals

*ling classifications vary for individual drugs since controlled substances ften marketed in combination with other medicinal ingredients.

**Designated a narcotic under the Controlled Substances Act.
***Designated a depressant under the Controlled Substances Act.

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Source: Drugs of Abuse, 3rd edition, DEA, Washington D.C. pp. 16-17.

Table 24-1 Indicators of Nurse Impairment

Physiological

Anorexia or uncontrolled eating
Insomnia
Muscular tension and aches, particularly head, neck, and back
Gastrointestinal disturbances
Increased blood pressure
Urinary frequency
Palpitations
Tightness in chest, difficulty breathing
Increased perspiration
Dryness of throat and mouth

Psychological

Feelings of disorganization, confusion, free-floating anxiety
Anger and frustration with people
Feeling helpless, impotent, indecisive, afraid
Difficulty concentrating
Tendency to blame others for problems

Behavioral

Increased carelessness, less attention to detail
Decreased problem-solving ability
Decreased concern and care for clients
Reduced creativity, work output
Increased use of alcohol and/or other drugs
Increased smoking
Accident proneness
Withdrawal, loss of interest in clients, peers, organizational activities
Increased absenteeism and tardiness
Increased complaining, expressed dissatisfaction
Frequent job change
Unreasonable work demands of self and/or others
Poor hygiene and appearance
Personal isolation, withdrawal from activities and friends
Sexual adjustment problems
Financial problems
Family abused or neglected; marital problems
Decreased personal pleasure time

Source: Duespohl, T. Audean, Nursing in Transition, "Indicators of Nurse Impairment," Aspen Publications, Rockville, Md., 1983, p. 214.

Table 24-2 Institutional Strategies for Enhancing Job Satisfaction and Preventing Impairment Among Nurses

1. Efficient management and conflict resolution practices
2. Responsive listening by administration; nursing input concerning policy of care
3. Open communication with managers, physicians, administrators
4. Realistic scheduling
   a. flexible staffing; part-time; job sharing
   b. employee input concerning scheduling and staffing
   c. encouragement of straight rather than rotating shifts
   d. not expecting double shifts or double-back shifts
   e. compensation for overtime and on-call
5. Climate that enhances physical and emotional well-being
   a. discretionary time off rather than sick time only
   b. adequate rest areas for staff
   c. incentives for staying well, such as bonus for minimal use of health insurance
   d. screening for cancer, diabetes, hypertension
   e. educational programs concerning smoking, obesity, substance abuse
   f. nutritional meals available every shift
6. Hospital-based referral programs for troubled nurses and their family members with guidance and counseling needs
7. Encouragement of continuing education, professional growth, and advancement; variety of experiences; career planning
8. Child care facilities
9. Maintenance of physical environmental factors (such as lighting, climate, air exchange, radiation control, and color) that are conducive to optimal productivity
10. Adequate orientation to the hospital, units, and procedures; adequate preparation for assigned roles and responsibilities; clear job descriptions

Source: Duespohl, T. Audean, Nursing in Transition, "Institutional Strategies for Enhancing Job Satisfaction and Preventing Impairment Among Nurses," Aspen Publications, Rockville, Md., 1983, p. 222.

Table 24-3 Self-Care Strategies for Prevention of Nurse Impairment

1. Awareness of symptoms of burnout
2. Awareness of potential causes of impairment
   a. frustration from ineffective and unsupportive management
   b. lack of growth and promotion opportunities
   c. hard-driving, idealistic, high-achieving personality
   d. unrealistic work expectations
   e. unsupportive climate with physicians, peers
   f. conflict of values with others in work environment
3. Development of peer support group in professional life
4. Nurturing of satisfying family and social relationships
5. Practice of stress management techniques
   a. relaxation
   b. adequate exercise and play
   c. adequate rest
   d. healthful nutrition
   e. self-affirming attitude
   f. minimal drug use
6. Practice of assertive communication to protect oneself from stagnation or overuse
7. Time management and prioritizing skills
8. Identification of personal and professional goals with a plan toward reaching them
9. Seeking intellectual stimulation and reward
10. Recognizing own psychophysiological capacity for productivity without overload

Source: Duespohl, T. Audean, Nursing in Transition, "Self-Care Strategies for Prevention of Nurse Impairment," Aspen Publications, Rockville, Md., 1983, p. 223.

STRESS-RELATED DISEASES

The following is a list of diseases or illnesses commonly associated with stress. These are not necessarily caused by stress; however, stress is often a major factor in the occurrence of the disease or illness.

HIGH BLOOD PRESSURE

HYPERTENSION

HEART ATTACK

OBESITY

KIDNEY MALFUNCTION

ULCER

ALCOHOLISM

SPASTIC STOMACH

HEADACHE

BACK PAIN

ALLERGY

RHEUMATOID ARTHRITIS

How many of these affect you?

Used with permission, Institute for Behavorial Awareness, 1978

Stress Buildup

Excess stress is one of the biggest causes of burnout. It overloads your circuits and saps your energy. Since most people don't have circuit breakers, the indications of too much stress are chronic headaches, ulcers, heart disease and job burnout.

The following test, Social Readjustment Rating Scale, developed by two Seattle physicians, T. H. Holmes and R. H. Rahe, can give you an indication of the amount of stress you are under. Add up the points in parentheses for each of the questions that applies to you.

In the last year have you had a:

___ Minor law violation (11)
___ Christmas (13)
___ Vacation (13)
___ Change in eating habits (15)
___ Change in number of family get-togethers (15)
___ Change in sleeping habits (16)
___ Loan or mortgage for less than $10,000 (17)
___ Change in social activities (18)
___ Change in recreation (19)
___ Change in church activities (19)
___ Change in residence (20)
___ Change in work hours or conditions (20)
___ Change in schools (20)
___ Trouble with your boss (23)
___ Change in appearance or habits (24)
___ Change in living conditions (25)
___ Spouse began or ceased work (26)
___ Begun or quit formal schooling (26)
___ Outstanding personal achievement (28)
___ Son or daughter leaving home (29)
___ Change in work responsibilities (20)
___ Trouble with in-laws (29)
___ Foreclosure of a loan or mortgage (30)
___ Mortgage over $10,000 (31)
___ Change in number of arguments with spouse (35)
___ Change in line of work (36)
___ Death of a close friend (37)
___ Change in financial status (39)
___ Sexual difficulties (39)
___ New family member (39)
___ Major business change (39)
___ Pregnancy (40)
___ Change in health of family member (44)
___ Retirement (45)
___ Marital reconciliation (45)
___ Lost your job (47)
___ Marriage (50)
___ Major personal illness or injury (53)
___ Death of family member other than spouse (63)
___ Jailed (63)
___ Marital separation (65)
___ Divorce (73)
___ Death of spouse (100)

___ Total

What does your score mean?	Total score		
		150 - 199	mild life crisis
		200 - 299	moderate life crisis
		300 +	major life crisis

Holmes, T. H. and Rahe, R. H. Journal of Psychosomatic Research: Vol. 11 1967, p. 216, Table II.

IS STRESS GETTING THE BEST OF YOU?

The following stress test is designed to give you an idea of what areas of your life have the highest stress levels. Keep track of your answers – at the end of the test is a table to tell you if it's time for you to try to be less tense.

A. **How would you describe your personality?**

1. tolerant, flexible, stable.
2. submissive, non-competitive.
3. hard-driving, impatient, perfectionist.

B. **Read the following list of feelings: neglected, panicky, nagged at, impatient, frustrated, burdened, mistreated, dependent, threatened, guilty, overwhelmed, paranoid, vengeful, angry, rushed, unloved, isolated, compulsive.**

How many of these words describe a way you often feel?

1. 0-5
2. 6-10
3. 11 or more.

C. **How would you describe your weight?**

1. Within 5 pounds of "ideal" weight.
2. Within 15 pounds of ideal.
3. Not within 15 pounds of ideal.

D. **Read the following list of life events: death of spouse, divorce, separation, jail term, death of a close family member, personal injury or illness, marriage, getting fired, retirement, marital reconciliation, pregnancy.**

How many of these life events have you experienced in the past year?

1. 0
2. 1
3. 2 or more.

E. **Read the following list of situations: financial state, line of work, job responsibilities, family life-style, school, residence, sleeping habits, eating habits, social or church activities.**

How many of these situations have changed for you during the past year?

1. 0-1
2. 2-3
3. 4 or more.

F. **How would you describe your job situation?**

1. artist, white collar, or athlete.
2. blue collar, professional, or executive.
3. unemployed or exposed to danger (policeman, for example).

G **How often do you smoke; drink alcoholic beverages; take drugs or medications; drink coffee, caffeinated tea, or cocoa?**

1. None on a daily basis.
2. Only one on a daily basis.
3. Two or more almost every day.

H. **How would you describe your eating habits?**

1. Low fat, sugar and salt; no snacks; balanced diet.
2. Moderate fat, sugar and salt; some snacks, balanced diet.
3. High fat, sugar and salt; many snacks, unbalanced diet.

I. **How many friends do you have?**

1. Many friends and acquaintances.
2. A few friends, few acquaintances.
3. No friends, few acquaintances.

J. **How often do you share your troubles with others?**

1. Regularly with family, friends, professionals.
2. A couple of times a week.
3. Rarely or never.

K. **How much do you sleep?**

1. 7½-8 hours a night.
2. 6-9 hours a night.
3. less than 6, more than 9 hours, including naps.

L. **How often do you use a relaxation technique (meditation, self-hypnosis, biofeedback, yoga)?**

1. Every day.
2. Once a week or more often.
3. Less than once a week.

M. **How often do you enjoy diversions (entertainment, recreational sports, hobbies) and vacations?**

1. Daily diversions, occasional vacations.
2. Occasional diversions, infrequent vacations.
3. Rare diversions, rare vacations.

N. **How often do you exercise?**

1. Several times a week, sometimes vigorously.
2. Once or twice a week.
3. Less than once a week.

O. **Where do you live?**

1. Country
2. Suburbs
3. City.

P. What's your marital status?

1. Married, first or second time.
2. Never married, divorced or widowed.
3. Twice divorced or widowed.

SCORING: Add up the numbers of your answers to get your total score. The lower the score, the less stress you are under, and the better you probably feel.

Excellent - 20 or fewer points.
Good - 21-26
Average - 27-35
Poor - 35 or higher

If you are interested in reducing the stress in your life, go back over your score and see what areas you might work on.

Used by permission, M. Lawrence Furst ***Stress for Success.***

Some of the factors that produce stress are outside of our control. However, it is often possible to modify some of the circumstances that are stressful to us.

A. Methods of alleviating stress in situations over which we have little or no control:

Meditation
Relaxation techniques
Exercise
Biofeedback
Massage
Diet
Adequate Rest
Accepting the fact that we cannot control the situation
Yoga

B. Methods of preventing or reducing stress in situations over which a large element of control is possible:

Group problem solving
Professional support groups
Interpersonal skill training
Human potential groups
Social literacy training
Professional counseling
Changing careers
"Flow" experiences

Northwest Staff Development Center, Dr. Dennis Sparks, Livonia, Michigan.

Drivers

Try Hard

"If I just struggle, I'll be OK."

Tries harder.

Doesn't answer questions directly.

Repeats questions.

Goes off on tangents. Says "It is hard for me."

Says "I don't know."

Believes "pauses" help.

Expects others to try hard.

Please Others

"If I just please them, I'll be OK."

Important to be liked.

Needs approval of others.

Nods head frequently. Says "uh-huh" often.

Asks "OK?" frequently.

Feels responsible for others feelings.

Looks away before answering questions.

Expects others to do same.

Be Perfect

"If I am just perfect, I'll be OK."

Strives for perfection.

Uses big words.

Tells more than is asked to tell.

Covers all bases.

Makes a positive comment and balances it with a negative.

Gives out lots of information so that "I'll be perfectly clear."

Expects the same of others.

Hurry Up

"If I just go faster, I will be OK."

Does things fast.

Talks rapidly.

Interrupts others.

Is a clock watcher.

Taps fingers impatiently.

Demands others hurry.

Believes there is never enough time.

Expects others to do the same.

Be Strong

"If I just hold in my feelings, I'll be OK."

Shows little excitement.

Believes feelings are of weakness.

Talks in monotone.

Holds in emotions.

Is stoical.

Keeps tight control of self.

Denies reality of stress, hurt, etc.

Expects others to do the same.

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Allower Attitudes

Try hard

Needs to Know and Chooses to Practice:

"I can do it well."

"I can do my best and take credit for it."

"I can finish what I start."

"I can win."

"I can succeed."

Please others

Needs to Know and Chooses to Practice:

"I can respect myself."

"I can consider my needs."

"I can say no."

"I can please myself."

Be perfect

Needs to Know and Chooses to Practice:

"I can be myself."

"I can make mistakes."

"I can be human."

"I can be real."

"I can accept failings."

Hurry up

Needs to Know and Chooses to Practice:

"I can take the time I need and accept that pace."

"I can live now and not hurry up."

"I can take my time."

Be strong

Needs to Know and Chooses to Practice:

"I can be open."

"I can own my feelings."

"I can be close and not be hurt."

"I can take care of my own needs."

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Do you act this way?

This list contains 30 behaviors and beliefs commonly held. Check the ten that most nearly reflect your own experience.

_____ 1. Try hard
_____ 2. Important to be liked
_____ 3. Strive for perfection
_____ 4. Do things fast
_____ 5. Show little excitement
_____ 6. Don't answer questions directly
_____ 7. Need approval of others
_____ 8. Use big words to explain things
_____ 9. Talk rapidly
_____ 10. Believe that feelings show weakness
_____ 11. Repeat questions before answering
_____ 12. Nod head and say "Uh-huh"
_____ 13. Tell in more detail than is necessary
_____ 14. Interrupt others
_____ 15. Talk in a monotone
_____ 16. Go off on tangents
_____ 17. Ask "O.K.?" frequently
_____ 18. Cover all the bases in discussions
_____ 19. Clock watcher
_____ 20. Hold in emotions
_____ 21. Say "I don't know"
_____ 22. Feel responsible for other's feelings
_____ 23. Balance out the positives and the negatives
_____ 24. Tap fingers, pencils, foot
_____ 25. Be stoical
_____ 26. Pause, clear throat, cough, etc., before responding
_____ 27. Glance away prior to responding to questions
_____ 28. Needs things to be perfectly clear
_____ 29. Doubt there is ever enough time
_____ 30. Keep self in tight emotional control

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Remember

- Not "Trying Hard" Does not Mean Quitting, Putting Out Less than Maximum Effort, or Lacking Motivation.

  It Does Mean Giving up a Guilt or Anxiety Producing Compulsion that Usually Blocks Positive Things from Happening.

- Not "Pleasing Others" does not Mean Becoming Selfish, Rude, Ill-Mannered or Aloof.

  The Behaviors We have Toward Others do not Usually Change Drastically. Our Rationale for Behavior, However, Changes from Compulsion to Free Choice.

- Not "Being Perfect" does not Mean to do a Less than Efficient, Thorough, Effective, Complete Job.

  It does Mean Freedom from the Pressure of Fearing Mistakes and Failure.

- Not "Hurrying-Up" does not Mean Missing Deadlines, Being Late, not Caring About Responsibilities.

  It does Mean Being Able to Decide on Pace and Priority Demands so that Performance Goes Forward with Minimal Stress and Tension.

- Not "Being Strong" does not Mean Being Emotionally Out of Control and Impulsive or Irresponsible in Behavior.

  It does Mean Being Free to be Myself and to Acknowledge How I am Affected by Things—and Still Choosing How to Respond.

- Exchanging "Driver Stress" for "Allower Freedom" is Maximizing Our Performance, not Minimizing or Reducing it.

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INSTRUCTIONS

Circle your answers from "Beliefs and Behaviors". The highest frequency indicates your predominant drivers.

Try Harder	Please Others	Be Perfect	Hurry Up	Be Strong
1	2	3	4	5
6	7	8	9	10
11	12	13	14	15
16	17	18	19	20
21	22	23	24	25
26	27	28	29	30

BILL OF RIGHTS

Personal Work

I HAVE THE RIGHT TO:

1. Refuse a request without having to feel guilty.
2. Feel and express anger.
3. Feel and express healthy competitiveness.
4. Use my judgment on which needs are most important to me.
5. Have my feeling given respect and consideration.
6. Make mistakes without feeling guilty.
7. Ask for affection and help. To make demands on others.
8. Be treated as a capable, human adult and not be patronized.
9. Change my mind.
10. Say "I don't know" or "I don't understand."
11. Question those in authority positions.
12. Open and honest relationships.
13. Courtesy and respect as a human being
14. Choose when to assert myself and when not to.
15. I have the right not to be perfect.

Source: Survive and Thrive: An NJEA Guide to Beating Burnout, NJEA, Trenton, N. J.

	VISIBLE QUALITIES	INNER FEELINGS	REPRESENTS TO FAMILY	CHARACTERISTICS	POSSIBLE FUTURE CHARACTERISTICS	
					WITHOUT HELP	WITH HELP
FAMILY HERO	VISIBLE SUCCESS DOES WHAT'S RIGHT	INADEQUATE	SELF-WORTH (FAMILY CAN BE PROUD)	HIGH ACHIEVER GRADES FRIENDS SPORTS	WORKAHOLIC NEVER WRONG RESPONSIBLE FOR EVERYTHING MARRY DEPENDENT	ACCEPT FAILURE RESPONSIBLE FOR SELF NOT ALL GOOD EXECUTIVES
SCAPEGOAT	HOSTILITY DEFIANCE ANGER	HURT GUILT	TAKES FOCUS OFF THE ALCOHOLIC	NEGATIVE ATTENTION WON"T COMPETE WITH "FAMILY HERO"	UNPLANNED PREGNANCY TROUBLE MAKER IN SCHOOL & LATER IN OFFICE PRISON	ACCEPT RESPONSIBILITY GOOD COUNSELORS COURAGE ABILITY TO SEE REALITY
LOST CHILD	WITHDRAWN LONER	LONELINESS UNIMPORTANT	RELIEF (ONE CHILD NOT TO WORRY ABOUT)	"INVISIBLE" QUIET NO FRIENDS FOLLOWER TROUBLE MAKING DECISIONS	Little zest for life sexual identity probs. promiscuous or stay alone Often dies at early age	INDEPENDENT TALENTED CREATIVE IMAGINATIVE
MASCOT	FRAGILE IMMATURE NEEDS PROTECTION	FEAR	FUN & HUMOR (COMIC RELIEF)	HYPERACTIVE LEARNING DISABILITIES SHORT ATTENTION SPAN	Ulcers, can't handle stress compulsive clown marry "hero" for care	Take care of self No longer clown Fun to be with Good sense of humor

HANDOUT #7

A LIST OF DON'TS

There are some things that one should definitely NOT do, under any circumstances, when dealing with an alcohol or other drug-addicted nurse:

1. DON'T lecture, moralize, scold, blame, threaten, or argue with the person about the problem. Document it and use it to counsel the person about job performance.

2. DON'T lose your temper.

3. DON'T "enable" the problem to continue by covering up the consequences, trying to protect, making excuses, or doing his/her job.

4. DON'T give the person an easier work schedule.

5. DON'T have a holier-than-thou attitude.

6. DON'T be overly sympathetic. You are not a counselor or a big sister.

7. DON'T accept what you know is a lie. When you know the nurse is lying, say so. Accepting lies only encourages more lying, and you will lose his/her respect at the same time.

8. DON'T accept mere promises to "do better," and don't keep switching agreements. When you say that a job is in jeopardy (suspension or termination) if performance does not improve, you must follow through.

9. DON'T accept the responsibility of letting someone work on your unit or team if impaired by alcohol or drugs. Judgment is the first to go.

10. DON'T put off facing the problem, hoping it will get better with time. It won't.

Helping the impaired nurse is difficult, but not impossible. The choices for action are varied, and the only choice that is clearly wrong is to do nothing.

SOURCE: Jefferson, Linda V. & Ensor, Barbara E., "Help for the Helper: Confronting a Chemically Impaired Colleague," American Journal of Nursing, Vol. 82, No. 4, April, 1982, p. 577.

HELP FOR THE HELPER

An Employee Assistance Program

BEST COPY AVAILABLE

By Barbara Elliott
Etta Williams

The Employee Assistance Program (EAP) at Baptist Memorial Hospital, Kansas City, Mo., began about five years ago. It started with training sessions to teach supervisors how to recognize, document, and refer job performance problems believed to be related to alcohol or drug dependency.

Regardless of suspected cause, the supervisor who notes poor job performance is expected to document the specific acts of conduct related to the employee's decline in job performance and counsel the employee. If the problem is suspected to be related to drug or alcohol dependency, the supervisor follows the written procedure for handling alcohol and drug abuse problems.

Step 1. The supervisor contacts the Employee Assistance Counselor (EAC) in the Employee Relations Department to confidentially discuss the problem and review the documentation.

Step 2. The supervisor continues to observe job performance; if it continues to deteriorate, the supervisor arranges a confidential session between the employee and the EAC.

Step 3. The EAC meets with the employee and attempts to get the employee to identify the exact nature of the problem causing a decline in job performance. Often, the employee health nurse is included in this meeting.

Step 4. When alcohol or drug dependency is identified as the problem, the employee is encouraged to take voluntary action. This usually begins with a referral to a local treatment facility which offers an evaluation and counseling service.

At this point, the problem becomes an employee health problem. After the employee meets with the counselor at the referral agency to discuss treatment needs and possibilities, the counselor confers with the employee health nurse and a treatment plan is finalized.

Thereafter, the employee health nurse meets with the employee from time to time to monitor progress. Records of these sessions are not part of the employment record and, in fact, are maintained separately from the routine personnel health record.

Step 5. When an alcohol or drug problem is identified and the employee refuses counseling or fails to follow the prescribed activity, the problem remains in the Employee Relations Department. The EAC informs the employee that, because of a continuing decline in work performance, participation in treatment is mandatory for continued employment.

Step 6. If the employee refuses mandatory participation in treatment, "termination of employment shall occur in accordance with the hospital's Separation and Termination for Cause policies."*

Since the program began, most of the employees referred by supervisors have accepted treatment instead of termination.

*Baptist Memorial Hospital, Kansas City, Mo. Procedure #2004 *Alcohol and Drug Abuse*, effective Apr. 1, 1977.

BARBARA ELLIOTT, RN, is the employee health nurse at Baptist Memorial Hospital in Kansas City, Mo.

ETTA WILLIAMS, RN, CAC, is the nursing coordinator on the alcoholism rehabilitation unit at Baptist Memorial Hospital and is president of the National Nurses Society on Alcoholism.

Management Guide on Alcoholism and Other Behavioral Problems

Excerpts from Kemper Groups EAP Policy

The Philosophy. An employee's choice to drink or not drink alcoholic beverages is a personal matter with which the company is not concerned. On the other hand, the illness of alcoholism and its effect upon work performance are matters of concern to the company.

Nothing in the following policy and procedure . . . will be construed to alter standard administrative procedures. Employees who develop alcoholism will receive the same consideration . . . as employees who have other illnesses and who accept appropriate treatment.

Administrative decisions regarding promotions, disciplinary actions and employment policies will be made in a manner consistent with the way situations involving chronic health problems, other than alcoholism, are handled.

Since alcoholism is a treatable illness, employees whose job performance becomes substandard will not be exempted from their personal obligation to seek diagnosis and appropriate treatment when alcoholism is suspected as a cause. . . .

With respect to the performance of employees, all levels of management and supervision are responsible for: 1. careful observation of performance levels, 2. accurate and complete documentation of performance declines and significant changes in employee work patterns, 3. consistent

BEST COPY AVAILABLE

Source: Elliot, Barbara and Williams, Etta, "Help for the Helper: An Employee Assistance Program," American Journal of Nursing, Vol.82 No. 4, April 1982, pp. 586-587

Potpourri of Resources

• **In Alabama,** Chuck Mann, RN, has started the HEMP (Help from Ex-addicts to Health Professionals) Foundation to educate nurses about drug abuse in the profession so that they can help their peers. For information, contact the HEMP Foundation at 1515 Huffman Road, Birmingham 35215.

• **In California,** informal networks to assist chemically impaired nurses have developed in three cities—San Francisco, San Jose, and Santa Rosa. The "parent," the San Francisco Support Group for Chemically Dependent Nurses, celebrated its first year of existence on March 27; the groups in San Jose and Santa Rosa each began in November 1981. All groups offer similar services: weekly support group meetings, treatment referral, legal referral for licensing and drug-related criminal problems, and education for health professionals and for employers. For information, contact the individual group in the specific city: Millicent Buxton or Marty Jessup, RN, Haight-Ashbury Training and Education Project, 409 Clayton St., San Francisco 94117, (415) 626-6763; Helen O'Neill, RN, 2653 Meridian Ave., San Jose 95124, (408) 257-1500; Susan Williams, RN, 465 A Street, P.O. Box 1628, Santa Rosa 95403.

• **In New Jersey,** two informal groups are trying to help impaired nurses—N.J. Nurses Concerned for Nurses and N.J. Nurses CARE (Committee on Addiction Rehabilitation and Education). For information contact Dorothy Harmsen, RN, Division of Alcoholism, N.J. State Health Dept., CN 365, Trenton 08625.

• **In North Carolina,** the Center for Well-Being of Health Professionals provides public and professional education. It is not a treatment center, but it offers treatment referral, aftercare, and career counseling to health professionals. The director is John-Henry Pfifferling, PhD, a medical anthropologist; the coordinator for the nurses unit is Alice Roye, RN. For information, contact the Center by writing 5529 Chapel Hill Blvd., Durham 27707, or calling (919) 489-9167.

• **In Wisconsin,** Mark Daley, RN, now director of satellite operations but director of nursing at the time, began the Impaired Nurse Program at DePaul Rehabilitation Hospital in Milwaukee. The program offers chemically dependent nurses a peer support group for outpatient therapy, inpatient detoxification, and AA involvement. The nursing coordinator of the program is Glenn Mueller, RN. For information, contact the Impaired Nurse Program, DePaul Rehabilitation Hospital, 4143 South 13th Street, Milwaukee 53221.

• **National** resources available free to anyone suffering from alcohol and/or other drug dependency include such self-help fellowships as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Pills Anonymous (PA). The primary service provided is the fellowship of others recovering from alcohol/drug impairment. In addition to meetings, these groups often have volunteers available on request to talk with someone impaired by alcohol or drug dependency. This is not professional counseling; it is one person recovering from impairment trying to help another, known in AA as "Twelfth Step Work." Local offices of AA, NA, or PA may be listed in the telephone directory. If they are not, lists of local offices in each state can be obtained by contacting:

Alcoholic Anonymous World Services, Inc.
Box 459
Grand Central Station
New York, N.Y. 10163
(212) 686-1100

World Services Office of Narcotics Anonymous
P.O. Box 622
Sun Valley, Calif. 91352
(213) 768-6203

Pills Anonymous
P.O. Box 473
Ansonia, N.Y. 10023

• **Teaching films** on how to recognize and help an alcohol-impaired professional (a physician in this series) have been released for free loan distribution. The series—four 20-minute films—is titled "Alcoholism and the Physician." The films were produced by and can be purchased from Operation Cork, Kroc Foundation, 8939 Villa La Jolla Drive, San Diego, Calif. 92037. For free loan, contact Modern Talking Picture Service, 500 Park Street North, St. Petersburg, Fla. 33709.

• **Employee Assistant Program** starter packets are available to health care facilities interested in developing a program to help alcohol- and/or drug-impaired employees. The packet, containing literature on what to consider and how to set up an EAP, can be requested on facility letterhead from the Labor-Management Department of the National Council on Alcoholism, Inc., 733 Third Avenue, New York, N.Y. 10017.

efforts to assist and motivate employees to correct work problems, and 4. working with appropriate staff personnel when a referral for diagnostic and/or treatment services is indicated by an employee's inability to correct performance through his or her own efforts.

Alcoholism Policy. In accordance with our general personnel policies, whose underlying concept is regard for the employee as an individual as well as a worker:

1. We believe alcoholism, or problem drinking, is an illness and should be treated as such.

2. We believe the majority of employees who develop alcoholism can be helped to recover and the company should offer appropriate assistance.

3. We believe the decision to seek diagnosis and accept treatment for any suspected illness is the responsibility of the employee. However, continued refusal of an employee to seek treatment when it appears that substandard performance may be caused by any illness is not tolerated. We believe that alcoholism should not be made an exception to this commonly accepted principle.

5. We believe that the company's concern for individual drinking practices begins only when they result in unsatisfactory job performance.

The objective of this policy is to retain employees who develop alcoholism by helping them to arrest its further advance before the condition renders them unemployable.

Source: Kemper Group. *Management Guide on Alcoholism.* Long Grove, Ill. The Company, 1975. pp. 2-7.

NEW JERSEY

ANNANDALE

TREATMENT AND REHABILITATION OF
ADDICTED PRISONERS (TRAP)
SOUTH CORRECTIONAL INSTITUTE
ANNANDALE, NJ 08801
(201) 638-6191
Alcoholism/Drug Abuse Treatment

ASBURY PARK

ASBURY PARK DRUG TREATMENT CENTER
1200 MEMORIAL DRIVE
ASBURY PARK, NJ 07712
(201) 988-8877
Drug Abuse Treatment

ATLANTIC CITY

ATLANTIC CITY DIV OF HEALTH
DETOX AND QUARTERWAY FACILITY
4100 BLACK HORSE PIKE
ATLANTIC CITY, NJ 08232
(609) 347-5475
Alcoholism Treatment

INSTITUTE FOR HUMAN DEVELOPMENT
(I H D) ADMINISTRATIVE UNIT
1315 PACIFIC AVENUE
ATLANTIC CITY, NJ 08401
(609) 345-4035
Alcoholism/Drug Abuse Services

INSTITUTE FOR HUMAN DEVELOPMENT
ALCOHOL RECOVERY PROGRAM
2400 FAIRMONT AVENUE
P.O. BOX 1383
ATLANTIC CITY, NJ 08401
(609) 348-6848
Alcoholism Treatment

INSTITUTE FOR HUMAN DEVELOPMENT
DRUG FREE OUTPATIENT CLINIC
1315 PACIFIC AVENUE
ATLANTIC CITY, NJ 08401
(609) 345-4035 EXT. 258
Drug Abuse Treatment

INSTITUTE FOR HUMAN DEVELOPMENT
METHADONE MAINTENANCE CLINIC
1315 PACIFIC AVENUE
ATLANTIC CITY, NJ 08401
(609) 345-4035
Drug Abuse Treatment

INSTITUTE FOR HUMAN DEVELOPMENT
RESIDENTIAL
1315 PACIFIC AVENUE
ATLANTIC CITY, NJ 08401
(609) 345-4035
Drug Abuse Treatment

BAYONNE

BAYONNE CITY ALCOHOLISM PROGRAM
630 AVENUE C
BAYONNE, NJ 07002
(201) 858-6916
Alcoholism Treatment

BELLE MEAD

CARRIER FOUNDATION
ADDICTION RECOVERY UNIT
BOX 147
BELLE MEAD, NJ 08502
(201) 874-4000 EXT. 261
Alcoholism/Drug Abuse Treatment

BERKELEY HEIGHTS

INTEGRITY INC
C/O JOHN E RUNNELLS HOSPITAL
BERKELEY HEIGHTS, NJ 07922
(201) 322-2110 EXT. 391
Drug Abuse Treatment

JOHN E RUNNELLS HOSPITAL
ALCOHOLISM REHABILITATION UNIT
PLAINFIELD AVENUE
BERKELEY HEIGHTS, NJ 07922
(201) 322-7240 EXT. 321
Alcoholism Treatment

NEW HORIZONS
1052 PLAINFIELD AVENUE
BERKELEY HEIGHTS, NJ 07922
(201) 322-2211
Alcoholism Treatment

BLAIRSTOWN

LITTLE HILL/ALINA LODGE
PAULINSKILL RIVER AND SQUIRES ROAD
PAULINSKILL RIVER & SQUIRES ROAD
BOX G
BLAIRSTOWN, NJ 07825
(201) 362-6114
Alcoholism Treatment

BRICK

BRICK OUTREACH CENTER
100 BRICK PLAZA
BRICK, NJ 08723
(201) 920-0377 EXT. 0878
Drug Abuse Treatment

BRIDGETON

CUMBERLAND COUNTY
ALCOHOLISM TREATMENT DEPARTMENT
CUMBERLAND COUNTY MEDICAL CENTER
BOX 28A
BRIDGETON, NJ 08302
(609) 455-8000 EXT. 265
Alcoholism Treatment

CUMBERLAND COUNTY
DRUG TREATMENT CENTER
CUMBERLAND DRIVE
CUMBERLAND COUNTY HOSPITAL
BRIDGETON, NJ 08302
(609) 455-5441
Drug Abuse Treatment

FAITH FARM
RD 1
BOX 342
BRIDGETON, NJ 08302
(609) 455-6145
Drug Abuse Treatment

BURLINGTON

BURLINGTON CNTY COMMUNITY ACTION PROG
ALCOHOLISM PROJECT
1304 NORTH ROUTE 130
LA GORCE SQUARE SHOPPING CENTER
BURLINGTON, NJ 08016
(609) 386-5800 EXT. 29
Alcoholism Services

BURLINGTON COUNTY ALCOHOLISM PROGRAM
NECK ROAD RD 2
BURLINGTON, NJ 08016
(609) 386-5777
Alcoholism Treatment

CAMDEN

CAMDEN COUNTY DETOX CENTER
1555 HADDON AVENUE
CAMDEN, NJ 08102
(609) 541-0192
Alcoholism Treatment

CAMDEN COUNTY DRUG ABUSE CLINIC
417 BROADWAY
CAMDEN, NJ 08103
(609) 757-2855
Drug Abuse Treatment

CAMDEN COUNTY TASC PROGRAM
500 MARKET STREET
CAMDEN, NJ 08101
(609) 757-8945
Alcoholism/Drug Abuse Services

HISPANIC HEALTH AND MH ASSOCIATION
LA ESPERANZA
709 MARKET STREET
CAMDEN, NJ 08102
(609) 963-3736
Drug Abuse Treatment

STEP UP CENTER
589 STEVENS STREET
CAMDEN, NJ 08102
(609) 964-1040
Alcoholism Treatment

WEST JERSEY HOSPITAL
ALCOHOLISM PROGRAM (ALCOVE)
MOUNT EPHRAIN AND ATLANTIC AVENUES
CAMDEN, NJ 08104
(609) 963-3180
Alcoholism Treatment

CLINTON

FEMALE ALCOHOL AWARENESS PROGRAM
(FAAP)
CORRECTIONAL INSTITUTION FOR WOMEN
DRAWER E
CLINTON, NJ 08809
(201) 735-7111 EXT. 218
Alcoholism Treatment

Source: National Directory of Drug Treatment Programs, U. S. Department of Health and Human Services, National Institute of Drug Abuse, Rockville, Md., pp. 159-166.

NEW JERSEY

COLLINGSWOOD

CAMDEN CNTY CTR FOR ADDICTIVE DISEASES
TURNING POINT
725 COLLINGS AVENUE
COLLINGSWOOD, NJ 08107
(609) 854-1222
Drug Abuse Treatment

DENVILLE

SAINT CLARES HOSPITAL
ALCOHOL TREATMENT SERVICES
POCONO ROAD
DENVILLE, NJ 07834
(201) 625-6382 EXT. 6382
Alcoholism Treatment

DOVER

HOPE HOUSE
19-21 BELMONT AVENUE
P.O. BOX 851
DOVER, NJ 07801
(201) 361-5555
Drug Abuse Treatment

US ARMY RESEARCH & DEVELOPMENT COMMAND
EMPLOYEE ASSISTANCE OFFICE
ATTENTION DRDAR-PTB
BUILDING 1610
DOVER, NJ 07801
(201) 328-5390
Alcoholism/Drug Abuse Treatment

EAST ORANGE

EAST ORANGE DRUG ABUSE PROGRAM
ADMINISTRATIVE UNIT
160 HALSTED STREET
EAST ORANGE, NJ 07018
(201) 266-5200
Drug Abuse Services

EAST ORANGE DRUG ABUSE PROGRAM
DRUG FREE UNIT
160 HALSTED STREET
EAST ORANGE, NJ 07018
(201) 266-5206
Drug Abuse Treatment

EAST ORANGE DRUG ABUSE PROGRAM
METHADONE MAINTENANCE UNIT
160 HALSTED STREET
4TH FLOOR
EAST ORANGE, NJ 07018
(201) 266-5200
Drug Abuse Treatment

EAST ORANGE GENERAL HOSPITAL
REHAB ALC FAMILY TRMT (RAFT)
300 CENTRAL AVENUE
EAST ORANGE, NJ 07019
(201) 672-8400 EXT. 301
Alcoholism Treatment

ELIZABETH

PROCEED INC
301 ELIZABETH AVENUE
ELIZABETH, NJ 07206
(201) 527-0418
Alcoholism/Drug Abuse Treatment

UNION COUNTY COUNCIL ON ALCOHOLISM
BRANCH OFFICE
645 LIVINGSTON STREET
ELIZABETH, NJ 07206
(609) 292-7145
Alcoholism Treatment

UNION COUNTY DETOX CENTER INC
323 NORTH BROAD STREET
ELIZABETH, NJ 07207
(201) 353-6830
Alcoholism Treatment

UNION COUNTY NARCOTIC CLINIC
43 RAHWAY AVENUE
ELIZABETH, NJ 07202
(201) 648-4602
Drug Abuse Treatment

UNION COUNTY TASC
PRETRIAL INTERVENTION PROGRAM
BROAD STREET
UNION COUNTY COURT HOUSE
ELIZABETH, NJ 07207
(201) 527-4364
Alcoholism/Drug Abuse Services

FLEMINGTON

HUNTERDON COUNCIL ON ALCOHOLISM
8 MAIN STREET
FLEMINGTON, NJ 08822
(201) 782-3909
Alcoholism Prevention

HUNTERDON MEDICAL CENTER
ALCOHOLISM SERVICES
ROUTE 31
FLEMINGTON, NJ 08822
(201) 782-2121 EXT. 341
Alcoholism Treatment

HUNTERDON MEDICAL CENTER
DRUG ABUSE PROGRAM
HUNTERDON MEDICAL CENTER
ROUTE 31
FLEMINGTON, NJ 08822
(201) 782-2121 EXT. 341
Drug Abuse Treatment

FORT DIX

FORT DIX COUNSELING CENTER
ALCOHOL AND DRUG ABUSE CONTROL BRANCH
U S ARMY TRAINING CENTER
PERSONNEL SERVICES DIVISION DPCA
FORT DIX, NJ 08640
(609) 562-4011 EXT. 3841
Alcoholism/Drug Abuse Treatment

GLASSBORO

DRUG TREATMENT PROGRAM
7 STATE STREET
GLASSBORO, NJ 08028
(609) 881-7045
Drug Abuse Treatment

HACKENSACK

ALCOHOL REFERRAL PROGRAM
65 EAST BROADWAY
HACKENSACK, NJ 07601
(201) 646-3336
Alcoholism Services

MONSIGNOR WALL SOCIAL SERVICE CENTER
75 EAST BROADWAY
HACKENSACK, NJ 07601
(201) 342-2565
Drug Abuse Treatment

HACKETTSTOWN

HACKETTSTOWN COMMUNITY HOSPITAL
ALCOHOLISM SERVICES
651 WILLOW GROVE STREET
HACKETTSTOWN, NJ 07840
(201) 852-5100 EXT. 308
Alcoholism Treatment

HAMMONTON

ANCORA PSYCHIATRIC HOSPITAL
MENTAL HEALTH/ALC TREATMENT PROGRAM
SPRING GARDEN ROAD
HAMMONTON, NJ 08037
(609) 561-1700 EXT. 417
Alcoholism Treatment

HOBOKEN

METROPOLITAN INSTITUTE FOR
HUMAN SERVICES
200 14TH STREET
HOBOKEN, NJ 07030
(201) 656-1576
Drug Abuse Treatment

SAINT MARY HOSPITAL CMHC
ALCOHOLISM OUTPATIENT TREATMENT PROG
609 WASHINGTON STREET
HOBOKEN, NJ 07030
(201) 792-3300 EXT. 2476
Alcoholism Treatment

HOLMDEL

NEW HOPE FOUNDATION
MARLBORO PSYCHIATRIC HOSPITAL
COTTAGE 13
HOLMDEL, NJ 07733
(201) 946-3030
Alcoholism Treatment

JERSEY CITY

HUDSON CLINIC (SSA)
430 JOHNSTON AVENUE
JERSEY CITY, NJ 07304
(201) 432-0184
Drug Abuse Treatment

HUDSON TREATMENT ALTERNATIVES TO
STREET CRIME (TASC)
114 CLIFTON PLACE
JERSEY CITY, NJ 07304
(201) 451-3404
Alcoholism/Drug Abuse Services

JERSEY CITY MEDICAL CENTER CMHC
ALCOHOL OUTPATIENT COUNSELING PROGRAM
30 BALDWIN AVENUE
CLINIC BUILDING 6TH FLOOR
JERSEY CITY, NJ 07304
(201) 451-9800 EXT. 2324
Alcoholism Treatment

KEARNY

DRUG AND ALCOHOL ABUSE
INFORMATION CENTER
430 KEARNY AVENUE
KEARNY, NJ 07032
(201) 997-4000
Drug Abuse Treatment

INTER/COUNTY COUNCIL ON
DRUG AND ALCOHOL ABUSE/ADMIN UNIT
416 KEARNY AVENUE
KEARNY, NJ 07032
(201) 997-4000
Drug Abuse Services

KEARNY METHADONE CLINIC
645 KEARNY AVENUE
KEARNY, NJ 07032
(201) 977-4000
Drug Abuse Treatment

PROJECT LIFE
BOYS CLUB INC
156 SCHUYLER AVENUE
KEARNY, NJ 07032
(201) 998-7575
Drug Abuse Treatment

KENDALL PARK

MIDDLESEX COUNCIL ON ALCOHOLISM
MIDDLESEX COUNTY DIVISION
3060 HIGHWAY 27
KENDALL PARK, NJ 08824
(201) 246-1450
Alcoholism Prevention

KEYPORT

BAY SHORE YOUTH SERVICES BUREAU
PROJECT HARMONY
1 ELIZABETH STREET
KEYPORT, NJ 07735
(201) 739-9595
Drug Abuse Treatment

ENDEAVOR HOUSE
6 BROADWAY
KEYPORT, NJ 07735
(201) 264-3824
Alcoholism Treatment

WOMENS RESOURCE AND SURVIVAL CENTER
10-16 BROAD STREET
KEYPORT, NJ 07735
(201) 264-4111
Drug Abuse Treatment

LAKELAND

CAMDEN CNTY CTR FOR ADDICTIVE DISEASES
TURNING POINT
COLLIER DRIVE
BLACKWOOD POST OFFICE
LAKELAND, NJ 08012
(609) 228-4200 EXT. 9
Drug Abuse Services

CAMDEN CNTY CTR FOR ADDICTIVE DISEASES
TURNING POINT INTERMEDIATE MED UNIT
COLLIER DRIVE
BLACKWOOD POST OFFICE
LAKELAND, NJ 08012
(609) 228-4200 EXT. 21
Drug Abuse Treatment

CAMDEN CNTY CTR FOR ADDICTIVE DISEASES
TURNING POINT RESIDENTIAL
COLLIER DRIVE
LAKELAND, NJ 08012
(609) 228-4200 EXT. 18
Drug Abuse Treatment

LAKEWOOD

NATIONAL COUNCIL ON ALCOHOLISM
OF OCEAN COUNTY
528 RIVER AVENUE
LAKEWOOD, NJ 08701
(201) 367-5515
Alcoholism Prevention

LAMBERTVILLE

HUNTERDON DRUG AWARENESS PROGRAM
45 CHURCH STREET
LAMBERTVILLE, NJ 08530
(609) 397-2708
Drug Abuse Treatment

LONG BRANCH

CHELSEA SCHOOL DRUG PROGRAM
152 CHELSEA AVENUE
LONG BRANCH, NJ 07740
(201) 222-5190
Drug Abuse Services

MONMOUTH MEDICAL CENTER
ALCOHOLISM TREATMENT PROGRAM
250 3RD AVENUE
POLLAK CLINIC
LONG BRANCH, NJ 07740
(201) 222-5200 EXT. 5051
Alcoholism Treatment

MONMOUTH MEDICAL CENTER
OUTREACH PROGRAM
120 DUNBAR AVENUE
LONG BRANCH, NJ 07740
(201) 222-5200 EXT. 3193
Drug Abuse Treatment

MANAHAWKIN

OCEAN CNTY PREVENTION/INTERVENTION
SERVICE FORCE FOR ALCOHOLISM
86 NORTH MAIN STREET
ROUTE 9
MANAHAWKIN, NJ 08050
(609) 597-1254
Alcoholism Treatment

MARLBORO

DISCOVERY HOUSE
MARLBORO STATE HOSPITAL
P.O. BOX 177
MARLBORO, NJ 07746
(201) 946-9444
Drug Abuse Treatment

MAYS LANDING

TREATMENT ALTERNATIVES TO STREET CRIME
(TASC)
MAIN STREET
ATLANTIC COUNTY COURT HOUSE
MAYS LANDING, NJ 08330
(609) 625-7000 EXT. 5436
Alcoholism/Drug Abuse Services

METUCHEN

ROOSEVELT HOSPITAL
ALCOHOLISM TREATMENT CENTER
37 OAKWOOD AVENUE
P.O. BOX 151
METUCHEN, NJ 08840
(201) 321-6800 EXT. 466
Alcoholism Treatment

MONTCLAIR

ALPHA CENTER
MONTCLAIR DRUG ABUSE CENTER
25: PARK STREET
2ND FLOOR
MONTCLAIR, NJ 07043
(201) 783-6322
Drug Abuse Treatment

MOUNTAINSIDE HOSPITAL
ALCOHOLISM TREATMENT CENTER
BAY AND HIGHLAND AVENUES
MONTCLAIR, NJ 07042
(201) 429-6121 EXT. 253
Alcoholism Treatment

WE HELP OURSELVES
PROJECT W H O
104 BLOOMFIELD AVENUE
MONTCLAIR, NJ 07042
(201) 783-6033
Drug Abuse Treatment

MORRISTOWN

ALFRE INC
MRS WILSONS
56 MOUNT KEMBLE AVENUE
MORRISTOWN, NJ 07960
(201) 540-0116
Alcoholism Treatment

NEW JERSEY

CENTER FOR ADDICTIVE ILLNESSES
95 MOUNT KEMBLE AVENUE
MORRISTOWN, NJ 07960
(201) 285-4700
Alcoholism Treatment

MARKET STREET MISSION INC
9 MARKET STREET
MORRISTOWN, NJ 07960
(201) 538-0431
Alcoholism Treatment

MORRIS COUNTY AFTERCARE CLINIC
95 MOUNT KEMBLE AVENUE
COMM MEDICAL CTR THEBAULD BLDG
MORRISTOWN, NJ 07960
(201) 267-2066
Drug Abuse Treatment

NATIONAL COUNCIL ON ALCOHOLISM OF MORRIS COUNTY INC
95 MOUNT KEMBLE AVENUE
MORRISTOWN, NJ 07960
(201) 267-8887
Alcoholism Prevention

MOUNT HOLLY

AMITY HOUSE
211 GARDEN STREET
MOUNT HOLLY, NJ 08060
(609) 267-6182
Alcoholism Treatment

BURLINGTON COUNTY ALCOHOL ABUSE PRGS
STARTING POINT
541 WOODLANE ROAD
MOUNT HOLLY, NJ 08060
(609) 261-5071 EXT. 5071
Alcoholism Treatment

BURLINGTON COUNTY METHADONE CLINIC
75-77 WASHINGTON STREET
MOUNT HOLLY, NJ 08060
(609) 267-9553
Drug Abuse Treatment

NEW BRUNSWICK

COMMUNITY ALCOHOLISM SERVICES PROGRAM
165 RENSEN AVENUE
NEW BRUNSWICK, NJ 08901
(201) 545-3327
Alcoholism Treatment

DAMON HOUSE
ADMINISTRATIVE UNIT
49 PATERSON STREET
NEW BRUNSWICK, NJ 08901
(201) 828-3988
Drug Abuse Services

DAMON HOUSE OF NEW BRUNSWICK
105 JOYCE KILMER AVENUE
NEW BRUNSWICK, NJ 08901
(201) 828-6002
Drug Abuse Treatment

MIDDLESEX COUNTY
TASC PROJECT
PROBATION DEPARTMENT
NEW BRUNSWICK, NJ 08903
(201) 745-3638
Alcoholism/Drug Abuse Services

NEW BRUNSWICK COUNSELING CENTER
89 MORRIS STREET
NEW BRUNSWICK, NJ 08901
(201) 246-4025
Drug Abuse Treatment

THE OPEN DOOR
18 ABEEL STREET
NEW BRUNSWICK, NJ 08901
(201) 246-4800
Alcoholism Treatment

NEW LISBON

BURLINGTON COUNTY HEALTH DEPARTMENT
POST HOUSE RESI/OUTPT DRUG FREE PROG
PEMBERTON/BROWNS MILLS ROAD
NEW LISBON, NJ 08064
(609) 894-4292
Drug Abuse Treatment

NEWARK

COMMUNITY AGENCY SERVING ALCOHOLICS
214 HAWTHORNE AVENUE
NEWARK, NJ 07112
(201) 824-9496
Alcoholism Treatment

COMMUNITY UNITED FOR REHAB OF ADDICT
C U R A INC
61 LINCOLN PARK
NEWARK, NJ 07102
(201) 622-3570
Drug Abuse Treatment

ESSEX COUNTY DRUG ABUSE CLINIC
969 MCCARTER HIGHWAY
NEWARK, NJ 07102
(201) 648-4030
Drug Abuse Treatment

GOODWILL HOME AND MISSIONS INC
79 UNIVERSITY AVE
NEWARK, NJ 07102
(201) 621-9560
Alcoholism Treatment

INTEGRITY INC
ADMINISTRATIVE UNIT
103 LINCOLN PARK
NEWARK, NJ 07101
(201) 623-0600
Drug Abuse Services

INTEGRITY INC
HOUSE A AND B
97-99 LINCOLN PARK
NEWARK, NJ 07101
(201) 623-0600
Drug Abuse Treatment

INTEGRITY INC
OUTREACH
37 LINCOLN PARK
P.O. BOX 1606
NEWARK, NJ 07101
(201) 623-0600
Drug Abuse Treatment

INTEGRITY INC
THE ALCON PROJECT
103 LINCOLN PARK
NEWARK, NJ 07101
(201) 621-1623
Alcoholism Treatment

MOUNT CARMEL GUILD
DETOXIFICATION UNIT
17 MULBERRY STREET
NEWARK, NJ 07102
(201) 624-6163
Drug Abuse Treatment

MOUNT CARMEL GUILD
NARCOTIC AND REHAB CENTER
17 MULBERRY STREET
NEWARK, NJ 07102
(201) 624-2405
Drug Abuse Treatment

MOUNT CARMEL GUILD
SOCIAL SERVICE CENTER
101 UNIVERSITY AVENUE
NEWARK, NJ 07102
(201) 621-7755
Alcoholism Treatment

MULTIPHASIC DRUG TREATMENT PROGRA
ADMINISTRATIVE UNIT
15 ROSEVILLE AVENUE
NEWARK, NJ 07102
(201) 482-5566
Drug Abuse Services

MULTIPHASIC METHADONE MAINTENANCE
15 ROSEVILLE AVENUE
NEWARK, NJ 07107
(201) 482-5566
Drug Abuse Treatment

NEWARK ALCOHOL DETOX
15 ROSEVILLE AVENUE
NEWARK, NJ 07107
(201) 483-0300
Alcoholism Treatment

NEWARK DETOXIFICATION UNIT
17-19 ROSEVILLE AVENUE
NEWARK, NJ 07107
(201) 648-2364
Drug Abuse Treatment

NEWARK RENAISSANCE HOUSE INC
80 NORFOLK STREET
NEWARK, NJ 07107
(201) 623-3386
Drug Abuse Treatment

SOUL HOUSE
165 COURT STREET
NEWARK, NJ 07103
(201) 643-3888
Drug Abuse Treatment

THE NEW WELL ADDICT REHAB CTR
15 ROSEVILLE AVENUE
NEWARK, NJ 07107
(201) 242-0715
Drug Abuse Treatment

UNITED COMMUNITY ALCOHOLISM NETWORK
U/CAN
14 PARK PLACE
NEWARK, NJ 07102
(201) 484-8820
Alcoholism Treatment

UNIVERSITY HOSPITAL
ALCOHOLISM TREATMENT CENTER
100 BERGEN STREET
NEWARK, NJ 07103
(201) 456-6389
Alcoholism Treatment

NEWTON

SUSSEX COUNCIL ON ALCOHOL INC
29 LIBERTY STREET
NEWTON, NJ 07860
(201) 383-4787
Alcoholism Prevention

ORANGE

CITY OF ORANGE DRUG AND
ALCOHOL ABUSE PROGRAM
32 NORTH DAY STREET
ORANGE, NJ 07050
(201) 266-4173
Drug Abuse Treatment

FAMILY SERVICE & CHILD GUIDANCE CENTER
PSYCHOTHERAPY
395 SOUTH CENTER STREET
ORANGE, NJ 07050
(201) 675-3817
Drug Abuse Treatment

PARAMUS

BERGEN PINES COUNTY HOSPITAL
ADDICTION SECTION OF PSYCHIATRY
EAST RIDGEWOOD AVENUE
PARAMUS, NJ 07652
(201) 967-4222
Alcoholism/Drug Abuse Treatment

FIRST STEP DETOX HOUSE FOR
ALCOHOL ABUSERS
SUPERINTENDENTS DRIVE
BERGEN PINES COUNTY HOSPITAL
PARAMUS, NJ 07652
(201) 646-2038
Alcoholism Treatment

MID BERGEN CMHC
SUBST ABUSE SERV/ACCESS AFTERCARE UNIT
11 PARK PLACE
PARAMUS, NJ 07652
(201) 265-8200
Alcoholism/Drug Abuse Treatment

SPRING HOUSE
HALFWAY HOUSE FOR ALCOHOLIC WOMEN
EAST RIDGEWOOD AVENUE
BERGEN PINES HOSPITAL BLDG 7
PARAMUS, NJ 07652
(201) 261-3582
Alcoholism Treatment

PARSIPPANY

MORRIS COUNTY
ALCOHOL RECOVERY CENTER
360 WEST HANOVER AVENUE
PARSIPPANY, NJ 07054
(201) 285-6686
Alcoholism Treatment

PASSAIC

PASSAIC ARTS
141 MADISON STREET
PASSAIC, NJ 07055
(201) 472-0364
Alcoholism Treatment

PASSAIC COUNTY DRUG ABUSE CLINIC
PASSAIC BRANCH
77 HOOVER AVENUE
PASSAIC, NJ 07055
(201) 777-2962
Drug Abuse Treatment

PATERSON

ALPHA HOUSE
396 STRAIGHT STREET
PATERSON, NJ 07501
(201) 345-6000
Drug Abuse Treatment

BARNERT HOSPITAL CENTER
ALCOHOLISM PROGRAM
660 BROADWAY
BARNERT MEMORIAL HOSPITAL
PATERSON, NJ 07514
(201) 684-6000
Alcoholism Treatment

CEDAR HISPANIC CLINIC
103 CEDAR STREET
PATERSON, NJ 07509
(201) 345-6000 EXT. 44
Drug Abuse Treatment

CEDAR OUTPATIENT CLINIC
103 CEDAR STREET
PATERSON, NJ 07509
(201) 345-6000 EXT. 44
Drug Abuse Treatment

DAMON HOUSE OF PATERSON
369 MARKET STREET
PATERSON, NJ 07501
(201) 279-5563
Drug Abuse Treatment

DISMAS HOUSE
396 STRAIGHT STREET
PATERSON, NJ 07501
(201) 345-6000
Drug Abuse Treatment

MAIN STREET DRUG ABUSE CLINIC
319 - 321 MAIN STREET
PATERSON, NJ 07505
(201) 279-9116
Drug Abuse Treatment

MCNULTY HALFWAY HOUSE
SNAP
101 CEDAR STREET
PATERSON, NJ 07501
(201) 279-7003
Alcoholism Treatment

PASSAIC COUNTY
TASC PROJECT
24 DEGRASSE STREET
PATERSON, NJ 07505
(201) 881-4063
Alcoholism/Drug Abuse Services

PATERSON ALCOHOLISM REHAB PROGRAM
18 CHURCH STREET
PATERSON, NJ 07501
(201) 279-8432 EXT. 33
Alcoholism Treatment

STRAIGHT AND NARROW INC
ALCOHOLISM PROGRAM
869 EAST 19TH STREET
PATERSON, NJ 07501
(201) 279-7003
Alcoholism Treatment

STRAIGHT AND NARROW INC
MOUNT CARMEL DETOX UNIT
396 STRAIGHT STREET
PATERSON, NJ 07501
(201) 345-6000
Alcoholism Treatment

STRAIGHT AND NARROW INC
MT CARMEL REHAB CTR FOR ALCOHOLICS
396 STRAIGHT STREET
PATERSON, NJ 07501
(201) 345-6000
Alcoholism Treatment

PENNS GROVE

NEW HOPE RETREAT
PENNSVILLE-AUBURN ROAD
RD 1 BOX 130
PENNS GROVE, NJ 08069
(609) 299-5262
Alcoholism Treatment

PERTH AMBOY

PERTH AMBOY ADDICTION CENTER
ESCAPE CENTER YOUTH COOP
486 LAWRIE STREET
PERTH AMBOY GENERAL HOSPITAL
PERTH AMBOY, NJ 08861
(201) 442-3700 EXT. 2170
Drug Abuse Treatment

RARITAN BAY MENTAL HEALTH CENTER
ALCOHOLISM TREATMENT UNIT
570 LEE STREET
PERTH AMBOY, NJ 08861
(201) 442-1666
Alcoholism Treatment

NEW JERSEY

TRIPLE 3
530 NEW BRUNSWICK AVENUE
PERTH AMBOY, NJ 08861
(201) 442-3700 EXT. 5185
Alcoholism Treatment

PHILLIPSBURG

NORTHWEST NEW JERSEY
COMMUNITY ACTION PROGRAM INC
PROSPECT STREET
OLD FIRTH SCHOOL
PHILLIPSBURG, NJ 08865
(201) 454-7000
Alcoholism Treatment

PISCATAWAY

CENTER FOR INDUSTRIAL HUMAN RESOURCES
CMHC OF RMS OUTPATIENT ALCOHOLISM PROG
UMDNJ-RUTGERS MEDICAL SCHOOL
P.O. BOX 101
PISCATAWAY, NJ 08854
(201) 463-4726
Alcoholism Treatment

PLAINFIELD

NEW BRUNSWICK COUNSELING
PLAINFIELD CENTER
519 NORTH AVENUE
PLAINFIELD, NJ 07060
(201) 757-8450
Drug Abuse Treatment

PROJECT ALERT
ALERTOP
332 WEST FRONT STREET
PLAINFIELD, NJ 07060
(201) 753-3082
Alcoholism Treatment

PROJECT ALERT
DUDLEY HOUSE
930 PUTNAM AVENUE
PLAINFIELD, NJ 07060
(201) 753-3395
Alcoholism Treatment

PRINCETON

CORNER HOUSE
369 WITHERSPOON STREET
VALLEY ROAD BUILDING
PRINCETON, NJ 08540
(609) 924-8018
Drug Abuse Treatment

FAMILY SERVICE AGENCY OF PRINCETON
OUTPATIENT ALCOHOLISM TREATMENT PROG
120 JOHN STREET
PRINCETON, NJ 08540
(609) 924-2098
Alcoholism Treatment

PRINCETON HOUSE
ALCOHOLISM UNIT
905 HERRONTOWN ROAD
PRINCETON, NJ 08540
(609) 734-4642 EXT. 4086
Alcoholism Treatment

RED BANK

NATIONAL COUNCIL ON ALCOHOLISM
OF MONMOUTH COUNTY
90 MONMOUTH STREET
RED BANK, NJ 07701
(201) 741-5200
Alcoholism Treatment

RED BANK AREA OUTREACH CENTER
21 MECHANIC STREET
RED BANK, NJ 07701
(201) 842-2000 EXT. 246
Drug Abuse Treatment

RIVERVIEW HOSPITAL
ARU/CENTURY HOUSE
35 UNION STREET
RED BANK, NJ 07701
(201) 741-2700 EXT. 415
Alcoholism Treatment

RIDGEWOOD

RAYMOND E BANTA VALLEY CENTER
301 NORTH VAN DIEN AVENUE
RIDGEWOOD, NJ 07451
(201) 445-4357
Alcoholism/Drug Abuse Treatment

RIVERSIDE

ZURBRUGG MEMORIAL HOSPITAL
RIVERSIDE/RANCOLAS VALLEY DIVISION
HOSPITAL PLAZA
RIVERSIDE, NJ 08075
(609) 461-6700 EXT. 339
Alcoholism Treatment

RUTHERFORD

CENTER FOR FAMILY/COMMUNITY EDUCATION
ADULT CHILDREN OF ALCOHOLICS
15 PARK AVENUE
RUTHERFORD, NJ 07070
(201) 460-7912
Alcoholism Treatment

SEABROOK

SEABROOK HOUSE
705 POLK LANE
BOX 55
SEABROOK, NJ 08302
(609) 455-7575
Alcoholism Treatment

SEWELL

SOUTH JERSEY COUNCIL ON ALCOHOLISM
RD 4
BOX 209
SEWELL, NJ 08080
(609) 228-7447
Alcoholism Prevention

SKILLMAN

CRAWFORD HOUSE INC
HALFWAY HOUSE FOR WOMEN ALCOHOLICS
SUNSET ROAD
SKILLMAN, NJ 08558
(201) 874-5153
Alcoholism Treatment

SOMERVILLE

SOMERSET COUNTY DRUG CLINIC
74 EAST HIGH STREET
SOMERVILLE, NJ 08876
(201) 722-4406
Drug Abuse Treatment

STIRLING

ALFRE INC
STIRLING HOUSE
1190 LONG HILL ROAD
STIRLING, NJ 07980
(201) 647-3498
Alcoholism Treatment

ALFRE INC ADMINISTRATION AND
FAMILY EDUCATION CENTER
1190 LONG HILL ROAD
STIRLING, NJ 07980
(201) 647-3498
Alcoholism Treatment

HONESTY HOUSE
ALCOHOLISM REHABILITATION TREATMENT
1272 LONG HILL ROAD
STIRLING, NJ 07980
(201) 647-3211
Alcoholism Treatment

SUMMIT

FAIR OAKS HOSPITAL
ALCOHOL RECOVERY UNIT (ARU)
19 PROSPECT STREET
SUMMIT, NJ 07901
(201) 277-1420
Alcoholism Treatment

OVERLOOK HOSPITAL
DRUG TREATMENT PROGRAM
193 MORRIS AVENUE
SUMMIT, NJ 07901
(201) 522-2837
Drug Abuse Treatment

TOMS RIVER

ED SCHAFFER HOUSE
ALCOHOLISM TREATMENT CENTER
1999 ROUTE 9
TOMS RIVER, NJ 08753
(201) 240-0423
Alcoholism Treatment

OCEAN COUNTY DRUG AND ALCOHOL PROGRA
C N 2191 SUNSET AVENUE
TOMS RIVER, NJ 08753
(201) 341-9700 EXT. 275
Alcoholism/Drug Abuse Prevention

OCEAN COUNTY HEALTH DEPARTMENT
METHADONE PROGRAM
2191 SUNSET AVENUE
TOMS RIVER, NJ 08753
(201) 988-6877
Drug Abuse Treatment

TOMS RIVER OUTREACH CENTER
247 MAIN STREET
TOMS RIVER, NJ 08753
(201) 244-1600
Drug Abuse Treatment

TRENTON

COMMUNITY GUIDANCE CENTER
ADDICTIONS SERVICES
528 WEST STATE STREET
TRENTON, NJ 08618
(609) 396-8810
Drug Abuse Treatment

FAMILY SERVICE ASSOCIATION OF TRENTON
COMPREHENSIVE ALCOHOLISM PLAN
143 EAST STATE STREET
M-5
TRENTON, NJ 08608
(609) 393-1626
Alcoholism Treatment

GUIDANCE CLINIC OF CATH WELFARE BUREAU
ALCOHOLISM COUNSELING AND TRT (ACT)
39 NORTH CLINTON AVENUE
TRENTON, NJ 08609
(609) 394-9398
Alcoholism Treatment

HENRY J AUSTIN HEALTH CENTER
MENTAL HEALTH DEPT SUBST ABUSE PROG
321 NORTH WARREN STREET
TRENTON, NJ 08618
(609) 989-3398
Alcoholism Treatment

MERCER COUNCIL ON ALCOHOLISM
548 BELLEVUE AVENUE
TRENTON, NJ 08618
(609) 396-5874
Alcoholism Treatment

MERCER COUNTY
AID TO LOW INCOME ALCOHOL ABUSERS
807 PARKSIDE AVENUE
TRENTON, NJ 08618
(609) 392-1822
Alcoholism Treatment

MERCER COUNTY
DRUG ABUSE CLINIC
132 PERRY STREET
2ND FLOOR
TRENTON, NJ 08618
(609) 292-3910
Drug Abuse Treatment

MERCER COUNTY
TASC PROGRAM
120 EAST FRONT STREET
TRENTON, NJ 08608
(609) 989-6729
Alcoholism/Drug Abuse Services

RESCUE MISSION OF TRENTON INC
VINCES PLACE
98 CARROLL STREET
P.O. BOX 617
TRENTON, NJ 08604
(609) 393-3533
Alcoholism Treatment

TREATMENT ALTERNATIVES TO STREET CRIME
(TASC) PRETRIAL SERVICES UNIT
MARKET STREET
TRENTON, NJ 08625
(609) 292-6286
Alcoholism/Drug Abuse Services

UNITED PROGRESS INC
DETOXIFICATION CENTER
541 EAST STATE STREET
TRENTON, NJ 08609
(609) 392-2822
Alcoholism Treatment

UNION CITY

NORTH HUDSON COMMUNITY ACTION CORP
(ARC) ALCOHOLIC REHABILITATION CENTER
507 26TH STREET
UNION CITY, NJ 07087
(201) 866-2258
Alcoholism Treatment

VAUXHALL

G H BASS INC
T/A SUBURBAN CLINIC
1 ROSELYN PLACE
P.O. BOX 124
VAUXHALL, NJ 07088
(201) 687-7188
Drug Abuse Treatment

VERONA

TURNING POINT INC
HILLTOP SANITARIUM ROAD
P.O. BOX 111
VERONA, NJ 07044
(201) 239-9400
Alcoholism Treatment

WASHINGTON

FAMILY GUIDANCE CENTER OF WARREN
21 WEST WASHINGTON STREET
WASHINGTON, NJ 07882
(201) 689-4478
Drug Abuse Treatment

WAYNE

WAYNE COUNSELING CENTER
475 VALLEY ROAD
WAYNE, NJ 07470
(201) 694-1234
Drug Abuse Treatment

WEST CALDWELL

THE BRIDGE
730 BLOOMFIELD AVENUE
WEST CALDWELL, NJ 07006
(201) 228-3000
Alcoholism/Drug Abuse Treatment

WEST ORANGE

WEST ORANGE FAMILY YOUTH SERVICE
MAYBE
32 MUNICIPAL PLAZA
WEST ORANGE, NJ 07052
(201) 325-4141
Drug Abuse Treatment

WESTFIELD

UNION COUNTY COUNCIL ON ALCOHOLISM INC
300 NORTH AVENUE EAST
WESTFIELD, NJ 07090
(201) 233-8810
Alcoholism Treatment

WHITING

AMERICAS KESWICK
KESWICK COLONY DIVISION
KESWICK GROVE
WHITING, NJ 08759
(201) 350-1187
Alcoholism Treatment

WILDWOOD

OPERATION JUNCTION
115-117 WEST DAVIS AVENUE
WILDWOOD, NJ 08260
(609) 729-1404
Alcoholism/Drug Abuse Treatment

WILLIAMSTOWN

MARYVILLE COLONY INC
GRANT AVENUE
RD 2 BOX 340C
WILLIAMSTOWN, NJ 08094
(609) 629-0244
Alcoholism Treatment

WOODBRIDGE

WOODBRIDGE ACTION FOR YOUTH
73 GREEN STREET
WOODBRIDGE, NJ 07095
(201) 634-7910
Drug Abuse Treatment

WOODBURY

GLOUCESTER COUNTY
HEALTH DEPT ALCOHOL ABUSE TRT PROG
CARPENTER ST. & ALLEN LANE
CARPENTER ST AND ALLEN LANE
WOODBURY, NJ 08096
(609) 845-1600
Alcoholism Services

404-063 O - 83 - 12

NEW JERSEY

MARYVILLE ALCOHOLISM REHAB CENTER
OUTPATIENT PROGRAM
426 NORTH BROAD STREET
WOODBURY, NJ 08096
(609) 848-3647
Alcoholism Treatment

REALITY HOUSE INC
C/O GLOUCESTER COUNTY HEALTH DEPT
CARPENTER STREET
WOODBURY, NJ 08096
(609) 848-0038
Drug Abuse Treatment

SERVICES TO OVERCOME DRUG ABUSE AMONG
TEENAGERS OF NJ INC (SODAT INC)
124 NORTH BROAD STREET
WOODBURY, NJ 08096
(609) 848-6363
Drug Abuse Treatment

WOODSTOWN

SALEM COUNTY ALCOHOL ABUSE
OUTPATIENT PROGRAM
SALEM WOODSTOWN ROAD
RR 2 BOX 346
WOODSTOWN, NJ 08098
(609) 769-2126
Alcoholism Treatment

HANDOUT #11

State of New Jersey

DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF NURSING
1100 RAYMOND BOULEVARD NEWARK, NEW JERSEY 07102

N I. KIMMELMAN
RNEY GENERAL

JAMES J. BARRY, JR.
DIRECTOR

June 7, 1983

N E W S L E T T E R

TO: All New Jersey Hospitals, Nursing Homes, Registries, Public Health Agencies and Schools of Nursing

FROM: New Jersey Board of Nursing

SUBJECT: Disciplinary Action Summary

The attached is a list of disciplinary actions taken by the New Jersey Board of Nursing from January 1, 1982 through April 6, 1983.

Marianna Baciçalupo

Marianna Baciçalupo, R.N., M.S.
Executive Secretary

Attachments

New Jersey Is An Equal Opportunity Employer

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REVOCATIONS

Guilty of:
C.D.S. Abuse
Penalty: Revocation
(April 22, 1983)

Guilty of:
C.D.S. Abuse
Penalty: Revocation
(March 9, 1983)

Gulty of:
C.D.S. Abuse
Penalty: Revocation
(May 27, 1983)

Guilty of:
Moral turpitude
Penalty: Revocation
(March 28, 1983)

Guilty of:
Moral Turpitude/conduct
derogatory to nursing
Penalty: Revocation
(April 22, 1983)

Guilty of:
C.D.S. Abuse
Lic. Revoked in Nevada & Florid
Penalty: Revocation
(May 7, 1982)

Guilty of:
C.D.S. Abuse
Penalty: Revocation
(May 27, 1982)

Guilty of:
C.D.S. Abuse
Penalty: Revocation
(February 17, 1981)

Guilty of:
C.D.S. Abuse
Penalty: Revocation
(April 30, 1982)

Guilty of:
C.D.S. Abuse
Penalty: Revocation
(July 20, 1982)

Guilty of:
C.D.S. Abuse
Penalty: Revocation
(July 20, 1982)

SUSPENSIONS

Guilty of: C.D.S. Abuse
Penalty: 5 years suspension
(3 years retroactive
to June 1979)

Guilty of:
C.D.S. Abuse
Penalty: 2 years Suspension
(August 31, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 18 mos. Suspension
2 years probation
(September 3, 1982)

Guilty of: C.D.S. Abuse
2 years suspension;
suspension stayed;
2 years probation
(December 21, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 6 mos. Suspension
1 year probation
$500.00 civil penalty
(December 29,1982)

Guilty of:
C.D.S. Abuse
Penalty: 2 years Suspension
1 year probation
(January 1, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 3 years Suspension
3 years probation
(October 19, 1982)

Guilty of:
Misrepresenting herself as a
licensed Midwife.
Penalty: 6 mos. Suspension
1 year probation
monetary penalty of $1,000.
Letter of reprimand.
(April 15, 1983)

Guilty of:
C.D.S. Abuse
Penalty: 18 mos. Suspension
(February 2, 1982)

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Guilty of:
C.D.S. Abuse
Penalty: 2 years Suspension
1 year probation
(May 28, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 18 mos. Suspension
2 years probation
(February 26, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 18 mos. Suspension
1 year probation
(May 12, 1981)

Guilty of:
C.D.S. Abuse
Penalty: 1 year Suspension;
Suspension stayed;
2 years probation
(February 18, 1983)

Guilty of:
C.D.S. Abuse
Penalty: 2 years Suspension
2 years probation
(October 19, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 15 mos. Suspension
(October 4, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 15 mos. Suspension
(June 24, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 1 year Suspension
2 years Probation
(April 26, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 1 year Suspension
3 years probation
(December 7, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 6 mos. Suspension
2 years probation
(June 1982)

Guilty of:
C.D.S. Abuse
Penalty: 2 years Suspension
(October 27, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 1 year Suspension
(September 21, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 2 years Suspension
1 year probation
(February 9, 1981)

Guilty of:
C.D.S. Abuse
Penalty: Temporary order of suspension
(November 6, 1981)

Guilty of:
C.D.S. Abuse
Penalty: Suspended until respondent h[illegible] successfully completed P.T.I. program and pending criminal charges against her have been dismissed.

Guilty of:
C.D.S. Abuse
Penalty: 18 mos. Suspension
3 years Suspension
(January 1, 1982)

PROBATIONS

Guilty of:
C.D.S. Abuse
Penalty: 1 year probation
(July 7, 1982)

PENALTIES

$250
2,500
1,500
750
1,500
500 (see page 2)
450
1,000 (see page 2)

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LICENSES REINSTATED

Reinstated October 19, 1982
License currently on probation
to October 1987.
Previously suspended on October
1, 1981 for 1 year for C.D.S.
Abuse.

Reinstated January 1, 1983
License currently on probation
to January 1, 1985.
Previously suspended on
January 1, 1983 for C.D.S. Abuse

Reinstated April 6, 1983
License currently on probation
to December 15, 1983.
Previously suspended for 1 year
on December 15, 1981 for C.D.S.
Abuse.

Reinstated April 6, 1983

Reinstated June 8, 1982
Previously suspended 6 mos.
and fined $250.00., on November
30, 1981 for C.D.S. abuse.

Reinstated April 15, 1983
License currently on probation
to April 1984. (See Page 3)

Reinstated January 4, 1983
License currently on probation
to January 4, 1986.
Previously suspended for 3 years
on Jan 4, 1980 for C.D.S. Abuse.

Reinstated June 9, 1982
Previously suspended for
one year March, 1981.

Reinstated April 6, 1983
Previously Revoked
September 10, 1976.

Dear Colleague,

This booklet has been written for you with the hope that it will give you some valuable information about nurse impairment with alcohol and/or drugs. Substance abuse among nurses is a growing concern, and if faced with the problem of dealing with it, either with a colleague or yourself, you will need to know what to do and how to do it.

This booklet and the accompanying curriculum are the products of New Jersey Department of Education, Division of Vocational Education Grant SCDG 404.

Beverly A. Keyes, R.N., B.S.N.
Instructor

Linda H. Stahl, R.N., B.S.
Coordinator of Health Occupations

Morris County Vocational School
Denville, New Jersey, 07834

6/30/84

LET'S TAKE A LOOK AT NURSE IMPAIRMENT

If you are concerned for your own involvement with drugs and/or alcohol

GOOD FOR YOU!

you have just taken the first step.

THERE IS HELP AVAILABLE

Find out if your employer has an Employee Assistance Program.

Call the appropriate hot line.

Contact a community resource.

Drug and Alcohol use and abuse have been around for thousands of years.

Nurses' involvement with alcohol and drug abuse often leads to loss of license, fines and penalties and loss of employment.

It is estimated that 100,000 nurses in the U.S. are impaired by alcohol and/or drugs.

TO: All New Jersey Hospitals, Nursing Homes, Registries, Public Health Agencies and Schools of Nursing

FROM: New Jersey Board of Nursing

SUBJECT: Disciplinary Action Summary

The attached is a list of disciplinary actions taken the New Jersey Board of Nursing from January 1, 1982 through April 6, 1983.

ilty of:
D.S. Abuse
y. Revoked if Neva
nalty: Revocation
ay 7, 1982)

ilty of:
D.S. Abuse
nalty: Revocation
ay 27, 1982)

ilty of:
D.S. Abuse
nalty: Revocation
ebruary 17, 1981)

ilty of:
D.S. Abuse
nalty: Revocation
pril 30, 1982)

ilty of:
D.S. Abuse
nalty: Revocation
uly 20, 1982)

ilty of:
D.S. Abuse
nalty: Revocation
ul" 20, 1982)

ilty of:
D.S. Abuse
nalty: Revocation
pril 22, 1983)

ilty of:
D.S. Abuse
nalty: Revocation
arch 9, 1983)

ty of:
D.S. Abuse
nalty: Revocation
ay 27, 1983)

ty of:
S. Abuse
lty: 2 years Susp
1 year proba
ruary 9, 1981)

ty of:
S. Abuse
lty: Temporary or
ension

Guilty of:
C.D.S. Abuse
Penalty: 18 mos. Suspension
2 years probation
(February 26, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 18 mos. Suspension
1 year probation
(May 12, 1981)

Guilty of:
C.D.S. Abuse
Penalty: 1 year Suspension;
Suspension stayed;
2 years probation
(February 18, 1983)

Guilty of:
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Penalty: 2 years Suspension
2 years probation
(October 19, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 15 mos. Suspension
(October 4, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 18 mos. Suspension
(June 24, 1982)

Guilty of:
C.D.S. Abuse
Penalty: 1 year Suspension
2 years Probation
(April 26, 1982)

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(December 29,1982)

Guilty of:
C.D.S. Abuse
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3 years probation
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C.D.S. Abuse
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1 year probation
(Nov 28, 1982)

Guilty of: C.D.S. Abuse
Penalty: 5 years suspension
(3 years retroactive
to June 1979)

Guilty of:
C.D.S. Abuse
Penalty: 1 year Suspension
(September 21, 1982)

ty of:
.S. Abuse
alty: Suspended until
respondent has successful.
completed P.T.I. program
pending criminal charges aga.
her have been dismissed.

Guilty of:
C.D.S. Abuse
Penalty: 18 mos. Suspension
3 years Suspension
(January 1, 1982)

These are warning signs

- ☐ Do you often take more than the recommended dosage of medicines?
- ☐ Do you save pills, just in case you need them?
- ☐ Do you self prescribe?
- ☐ Do you wake up at night feeling anxious?
- ☐ Do you conceal the number of pills you take?
- ☐ Do you "need" a drink or a pill to calm you down?
- ☐ Do you have memory lapses?
- ☐ Are you becoming withdrawn and/or unsociable?
- ☐ Are you relieved when you take a pill, but more nervous when it wears off?

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If you are concerned that a colleague is impaired, you must do something, but

DON'T lecture, moralize or threaten.

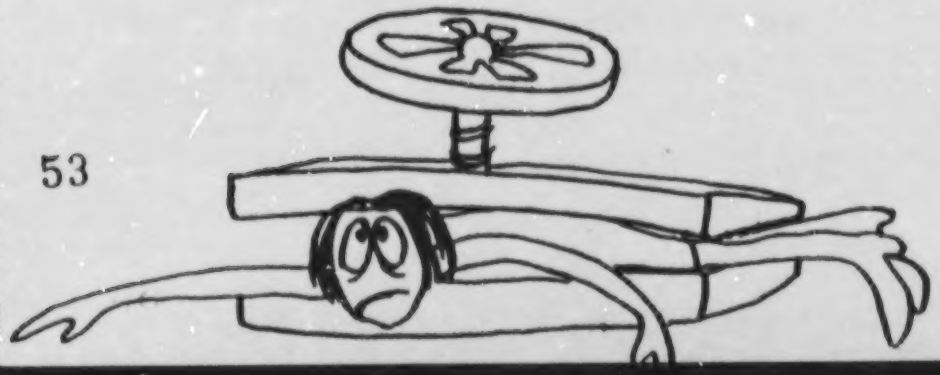
DON'T lose your temper.

DON'T cover up for him/her.

DON'T counsel unless you are trained.

DON'T ignore the problem.

DON'T accept the responsibility



The nurse impaired by alcohol and/or drugs is a hazard to him/herself and to the patients

Work Performance Suffers

unable to make decisions

frequent absence

forgetful

errors in nursing judgment

accident prone

excessive errors

loss of interest

decreased care and concern

Physical and Mental Conditions Suffer

anxiety

insomnia

GI upsets

headaches

poor hygiene

backaches

accidental injuries

The use of drugs by a nurse often includes

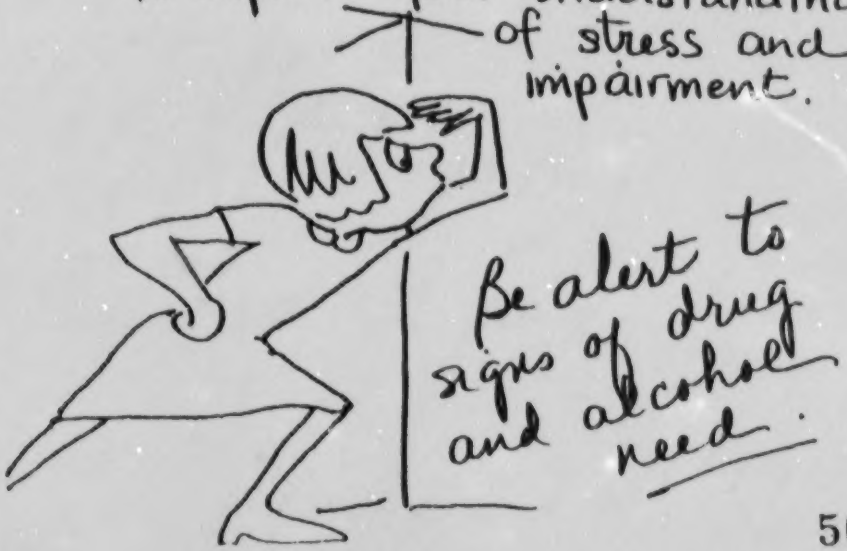
DIVERTING PATIENT MEDICATIONS
FALSIFYING RECORDS

The availability of drugs is a contributing factor in nurse impairment.

Although alcohol is the most widely abused substance, Demerol is the drug most frequently abused by nurses.

Try to decrease the chances of becoming personally involved in alcohol and/or drug abuse.

1. Know the signs and symptoms of stress and of burnout.
2. Never self-prescribe. Don't take medicine unless it is absolutely necessary.
3. Identify your own goals for employment. Make them realistic
4. Don't try to be super-nurse. Being all to everyone is really impossible.
5. Attend and initiate workshops to improve your understanding of stress and impairment.



Try to identify the

STRESS

you feel.

Practice stress management:
Eat well and get rest.
Get "away from it all."
Learn relaxation techniques.
Exercise.

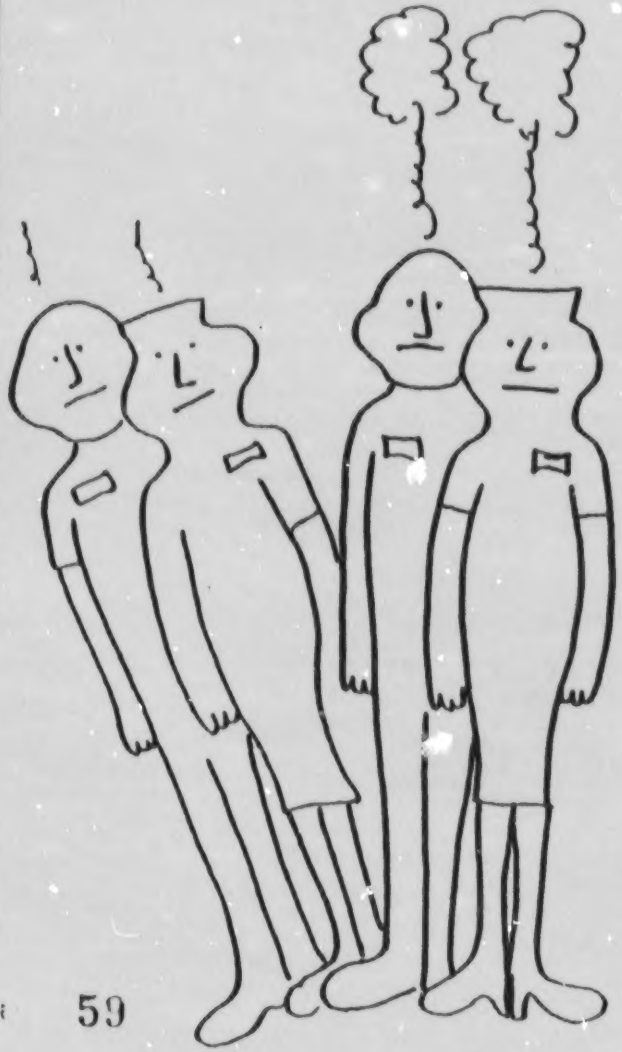
There are familial tendencies which may predispose you or a colleague to drug and/or alcohol involvement.
A family history of alcoholism is a known predisposing factor
DON'T IGNORE IT.

There are other predisposing factors in nurse impairment. Many of these are related to the **STRESS** connected to the job.

Frequent rotating shifts disrupt our internal clocks and thereby can cause emotional and physiological stress.

Once interrupted, it takes 12 days to readjust internal clocks

BURNOUT can cause a state of "mental anesthesia" for the nurse who feels constant tension and anxiety.



Professional and personal **ROLE ADJUSTMENT** can cause tremendous stress.

Making the transition from student to graduate

Returning to work.

changing jobs

Having financial worries

Having no one to talk to about your concerns.

Offering support to patients and families – and getting none for yourself.

I. PRE/POST TEST

I. Match the following terms with the definitions listed:

1. _____	Dex, Dexies	A.	Cocaine
2. _____	Juice	B.	Secobarbital
3. _____	Angel Dust	C.	Coming down; falling asleep
4. _____	Kit	D.	Overdose
5. _____	Up, Uppers	E.	Dextroamphetamine, all forms
6. _____	Down, Downs, Downers	F.	Alcoholic beverage; also "connections"
7. _____	Coke	G.	Any stimulant drug
8. _____	O.D.	H.	Any sedative drug
9. _____	F-40's	I.	Phencyclidine (PCP)
10. _____	Crash	J.	Hypodermic equipment

II. TRUE/FALSE

11. _____ Patients find it safer and more convenient to vent their frustrations on the nurse rather than the physician.

12. _____ Nursing is a secure economic career that can be re-entered at any time.

13. _____ A 12 oz. bottle of beer contains approximately the same amount of alcohol as 5 oz. of wine or 1½ oz. of 80 proof liquor.

14. _____ Increased tolerance to alcohol may lead to physical dependence.

15. _____ Withdrawal from meperidine does not cause physically observable symptoms.

16. _____ Amphetamines are used to induce sleep.

17. _____ Poor hygiene and appearance may be indicators of nurse impairment.

18. _____ A moderate intake of alcohol may act as a mild sedative, facilitating falling asleep.

19. _____ Fear, stress, anger and fatigue may alter a person's rate of absorption of alcohol.

20. _____ Money is not that important to nurses, since rewards will come from service to others.

21. _____ Approximately 25% of the State Board of Nursing license status reviews are for controlled drug substance abuse.

22. _____ Substance abuse by a nurse may lead to revocation of license.

23. _____ Psychological dependence always results in physical dependence.

24. _____ Alcohol is classified as a stimulant.

25. _____ Most impaired nurses graduated in the top third of their class and have idealistic, high-achieving personalities.

III. MULTIPLE CHOICE

26. _____ Frustration for the new nurse graduate comes from all except:

A. giving quality care in an ill-defined health care system
B. hard work
C. inadequate orientation period
D. poorly defined job description

27. _____ Prevention of nurse impairment should come from:

A. the nurse
B. the profession
C. the health-care institute
D. all of the above

28. _____ Which of the following is the most commonly abused drug among nurses?

A. Demerol
B. Codeine
C. Alcohol
D. Valium

29. _____ When faced with a chemically impaired colleague, the nurse should:

A. get angry, to show you are concerned
B. give the colleague a lighter assignment until "problems" are worked out.
C. accept the colleague's promise to do better
D. not put off facing the problem & report it to the supervisor immediately

30. _____ Rotating shiftwork upsets known circadian rhythms of the body. It takes ____ days for the body temperature and performance to resynchronize:

A. 5 days
B. 48 hours
C. 12 days
D. 1 month

31. _____ Withdrawal from narcotics produces the following symptoms except:

A. watery eyes, runny nose
B. prolonged periods of sleep
C. yawning
D. panic, chills, sweating

32. _____ One of the first effects on the user of controlled substances and/or alcohol is:

A. loss of memory
B. loss of judgment
C. disorientation
D. slurred speech

33. _____ What classification of drug might the nurse use to achieve the same effect as alcohol?

A. Hallucinogens
B. Stimulants
C. Cannabis
D. Depressants

34. _____ Prevention of nurse impairment depends on adequate control of:

A. burnout
B. stress
C. relaxation techniques
D. all of the above

35. _____ Approximately _____ nurses in the U.S. are considered impaired:

A. 10,000
B. 40,000
C. 80,000
D. 100,000

ANSWER KEY - PRE/POST TEST

I. MATCHING - 2 points each

1. E
2. F
3. I
4. J
5. G
6. H
7. A
8. D
9. B
10. C

II. TRUE/FALSE - 2 points each

11. T
12. F
13. T
14. T
15. F
16. F
17. T
18. T
19. T
20. F
21. F
22. T
23. F
24. F
25. T

III. MULTIPLE CHOICE - 5 points each

26. B
27. D
28. C
29. D
30. C
31. B
32. B
33. D
34. D
35. D

II. INTRODUCTION

For thousands of years, people have experimented with a variety of naturally occuring substances that act on human nervous tissues; alcohol to intoxicate a weary mind; belladonna to calm an angry intestine or to poison an adversary, opium to overcome worry and strain. The relief of pain, in particular, is an ancient aim of mankind, and various narcotic and sleep-producing agents were probably used by primitive people. But for many, there is another kind of pain -- the pain of existing -- and since ancient times people have been trying to expand their vision, enhance their appreciation of the world, change their mood, alter their inner existance or stupefy their awareness with such drugs as alcohol, opium and cannabis.

Alcohol has been used in many cultures and has been worshipped as a god. Opium has also been used extensively at least since the time of ancient Greece. Homer tells how some of Odysseus' crew succumbed to forgetfulness in the land of the lotus-eaters.

Native societies of the Western Hemisphere have utilized, apparently for thousands of years, plants containing hallucinogenic substances. The sacred mushrooms of Mexico were called "God's flesh" by the Aztecs.

In the southwestern United States, the Mescalero Apaches practiced a peyote rite in the 19th century which was adopted by many of the Plains tribes. Psychedelic drugs have the unusual ability to evoke at least one kind of a mystical-religious experience and a positive change in religious feelings commonly found in studies of the use of these drugs. Whether they are capable also of producing religious lives is an open question. Their supporters argue that the drugs appear to enhance personal security and that from self-trust may spring trust of others and that this may be the psychological soil for trust in God.

In the words of Aldous Huxley (The Doors of Perception): "When, for whatever reason, men and women fail to transcend themselves by means of worship, good works and spiritual exercise, they are apt to resort to religion's chemical surrogates."[1]

III. CLASSIFICATION OF COMMONLY ABUSED DRUGS

A. Central Nervous System Depressants

1. Substances

Barbituric Acid Derivatives (Amytal, Nembutal, Seconal, Luminal)
Bromides
Ethyl Alcohol
Minor Tranquilizers (Librium, Tranxene, Valium, Miltown)
Non-Barbituate Sedatives (Noctec, Dalmane, Quaalude)
Phencyclidine (PCP)
Phenothiazines (Thorazine, Compazine, Mellaril)

2. Basic Pharmacology

This class of drugs produces sedation, sleep and coma due to the generalized depression of the CNS. Often the "down" effect is preceded by a period of disinhibition, manifested by excited, agitated behavior.

Cross-tolerance and cross-dependence exist among most drugs in this class.

3. Context of Use

Intoxication due to a combination of ethly alcohol and barbituates represents the most frequent and most potentially lethal medical crisis due to drugs.

Ethyl alcohol and the sedatives, particularly barbituates, are the most frequently abused CNS depressants, producing a severe emotional and physical dependency. Some non-barbituates may cause psychological or physical dependence.

4. Overdose/Symptoms

Acute toxicity due to CNS depressants may be identified by a state of inebriation. Slurred speech, unsteady gait, giggling and crying are common manifestations.

In severe cases, the individual is comatose, although the deep reflexes may persist for an extended period. Respiration may be slowed, or it may be rapid but shallow, accompanied by a drop in blood pressure.

A state of typical shock rapidly ensues with a weak and rapid pulse, cold and sweaty skin and an elevated hematocrit.

B. Central Nervous System Stimulants

1. Substances

Amphetamine (all forms)
Cocaine
Methylphenidate (Ritalin)
Phenmetrazine (Preludin)

2. Basic Pharmacology

In low doses, these stimulants produce increased alertness, a sense of well being, and appetite suppression. Tolerance to many effects develops rapidly. True physiologic dependency after prolonged use has not been clearly demonstrated but a physiologic "abstinence syndrome" has been observed in many cases. Mental depression and psychotic episodes are not uncommon after prolonged high-dose usage.

3. Context of Use

Spree use of DNS stimulants is most common. Short-term repetitive use for appetite suppression is usually accomplished under medical supervision. However, due to rapid development of tolerance, many individuals will continue to increase dosage.

4. Overdose/Symptoms

Panic, delerium, agitation, euphoria and belligerence are exhibited in cycles or combination. In the absence of tolerance, hyperpyrexia, arrythmias, hypertension, and dilated pupils may be present. In the individual with a history of prolonged high-dose use, hallucinations and paranoid ideation are usually present.

Intravenous use of amphetamines may be associated with arteriole damage to the kidneys. Massive overdoses usually produce convulsions, circulatory collapse, cerebral hemorrhage and coma and may result in death.

C. Psychedelics (of or causing extreme changes in the conscious mind, as hallucinations, delusions, intensification of awareness and sensory perception, specifically stimulating the auditory or visual effects of the psychedelic state.)

1. Substances

*Cannabis (all derivatives and forms)
Diethyltryptamine (DET)
Dimethyltriptamine (DMT)
D-Lysergic Acid Diethylamide (LSD)
Mescoline (Peyote Cactus)
Methylene Dioxyamphetamine (MDA)
Morning Glory Seeds (Myristicin)
Nutmeg
Psilocybin (from Mexican mushrooms)

*Categorization of Cannabis is difficult and depends on dose, with lower doses producing effects more analogous to the sedative hypnotics, while higher doses produce "psychedelic" effects.

2. Basic Pharmacology

These substances produce a wide range of intense effects.

The only clearly identified physical effects are a pupillary dilation (with all but cannabis) and some nausea accompanied by abdominal cramping. The dominant effects are perceptual and psychological in nature, which may occur with a wide variation of frequency and intensify at different times in a single individual.

Rapid alteration of affect, synesthesia (e.g. a specific color evokes a specific smell sensation), alteration of body image, heightened suggestibility, panic, depersonalization, agitation, visual illusions, and aggressive behavior are the most common responses. Physical dependence on psychedelics has not been demonstrated. Tolerance appears to develop and subside rapidly (to LSD).

Most of these substances are rapidly cleared from the body although effects may persist for 6 - 72 hours, depending on dosage and individual response.

Due to the lack of major physical effects, "overdose" and "acute toxicity" are synonymous for purposes of diagnosis and treatment.

3. Context of Use

Although experimental use of psychedelics continues to be a major component of the youthful "drug scene", a decreasing number of acute toxicity crises are being seen by health professionals.

The sophistication of current users based on the many crises which occurred during the 1960's has all but eliminated the need for medical assistance with adverse reactions.

On the street, LSD, phencyclidine (PCP) and belladonna alkaloids alone or in combination are frequently sold in place of other substances in this drug class.

4. Acute Toxicity/Symptoms

No clearly identifiable symptomatology is available for diagnosing an acute crisis due to psychedelics.

In general, either the individual or friends will provide information to identify the probable drug ingested and a pattern of response.

Most commonly, the individual will be panicky stating that a fear of not "coming down" is predominant.

Thought processes in such a state may mimic a psychotic episode, with a variety of bizarre responses to the environment possible.

D. Volatile Hydrocarbon Anesthetics

1. Substances

Carbon Tetrachloride
Freon (and other propellants)
Gasoline
Glue

2. Basic Pharmacology

Organic solvents produce a wide range of effects at low dosages, generally mimicking a sedative-type intoxication with some level of hallucinosis.

No tolerance or dependency has been demonstrated.

3. Context of Use

Young people (9-14) are most frequently users of solvents in lieu of using drugs available to older populations.

Inhaling of vapors is accomplished with a paper bag or other confined breathing device.

4. Overdose/Symptoms

Anoxia due to pulmonary air replacement is most common, with cardiac disturbances usually presetn.

Combativeness and hallucinosis may be concomitants in an acute episode.

Severe damage to vital organs is a possible concomitant even after short-term repetitive use.

E. Opiates

1. Substances

Codeine
Heroin
Laudanum
Meperidine (Demerol)
Methadone
Methadyl Acetate (LAM, LAMM)
Morphine
Opium
Paregoric
Pentazocine (Talacen, Talwin)
Propoxyphene (Darvon et al)

2. Basic Pharmacology

Opiate drugs produce sedation, analgesia, sleep and coma.

Respiratory depression is marked, but dose-dependent.

Detached euphoria and periods of drowsiness (nodding) are common manifestations of non-toxic doses.

Tolerance develops rapidly witn repeated use and physiologic dependence has been clearly demonstrated.

3. Context of Use

Heroin is the most frequently used opiate drug for other than legitimate health reasons. It is usually injected under unsterile conditions with lactose/mannitol as the accompanying powder for bulk.

Initial use is for pleasure but repetitive use can be to provide relief from withdrawal symptomatology.

4. Overdose/Symptoms

Pinpoint pupils, severe respiratory distress, and coma are the classic triad of opiate overdose symptomatology.

In advanced cases of massive overdose, however, pupillary dilation can be present. Nausea and retching are frequent concomitants. Pulmonary edema may be present.

HANDOUTS: 1. Glossary of Street Terms
2. Controlled Substances: Uses and Effects

IV. ALCOHOLIC SUBSTANCES

A. General Review

1. Alcohol, a drug, is a central nervous system depressant, easily made, and is the mood-altering ingredient in wine, beer and liquor.

2. Wines are fermented from the sugars in fruits, berries (most commonly grapes), from various plants, honey, even milk.

3. Beers are fermented from grains after the starch in them is first converted to sugar.

4. Spirits are distilled from wines or beers.

5. Extremely small amounts of other alcohols (methyl, propyl et al) along with other so-called congeners including acids, aldehydes, keytones, et al, also occur in alcoholic beverages. The combination and exact amounts of congeners vary with the type of beverage, ranging from 33 mgm per litre in vodka, which is purified diluted alcohol, to averages of 500 mgm per litre in some whiskies and 2600 in specially aged whiskies or brandies. Congeners contribute special characteristics of taste, aroma and color to the beverages. Some have medicinal effects, and some in spite of their small quantity, slow the rate at which the body disposes of ethyl alcohol (the main ingredient) and may have toxic effects if very large amounts of alcoholic beverages are consumed.

B. Alcoholic Content of Beers vs. Wines vs. Spirits

1. Beers -- In beers, the alcohol content varies from about 2% in some mild Scandanavians to about 8% in especially strong types; most U. S. beers contain between 4% and 5%. All percentages are by volume.

2. Natural or unfortified wines (e.g. dry wines such as burgundy, chianti and sauterne) usually contain between 8-12% alcohol, although most U. S. varieties contain from 12-14%. Vermouths and aperitif wines usually contain 18% and dessert, sweet and cocktail wines (sherry, port, muscatel) contain 20-21% by volume.

3. Spirits, including vodka, gin, and whiskies (rye, scotch, bourbon), rum, brandies and liqueurs (flavored syrupy spirits) most often contain 40-50% alcohol with some distilled spirits ranging up to nearly 100%. The U. S. proof stated on the bottle is equal to twice the amount of alcohol it contains. For example, 100 proof whiskey contains 50% alcohol, while 80 proof contains 40%.

Cordials, made of flavored spirits, such as anisette, blackberry, curacao, and sloegin, usually contain between 25% and 40%.

4. An average serving of most alcoholic beverages contains about the same amount of alcohol. A 12 oz. bottle of beer contains approximately the same amount of alcohol as 4-5 ounces of wine, or 1 1/2 ounces of 80 proof liquor. Wine may be a connoisseurs drink, but it packs more of a wallop than most people think. Wine punch can be particularly deceiving because of the sugar and other ingredients that may alter the taste. The alcohol in wine has the same effect as an equal amount of alcohol in distilled spirits, and despite its relatively mild alcoholic reputation, beer contains that same alcohol.

C. Blood Levels

1. Areas of absorption - When an alcoholic beverage is swallowed, it is diluted by stomach juices, and very quickly distributed throughout the body. Alcohol does not require digestion before its absorption into the blood stream. About 20% is absorbed directly from the stomach wall, and approximately 80% is absorbed more quickly from the small intestine.

2. Rate of absorption - The rate of absorption will vary according to:

a. the concentration of alcohol in the beverage consumed

b. the amount of alcohol consumed

c. the rate of drinking

d. the amount of food in the stomach (usually delays - especially fatty foods)

e. the non-alcoholic substances in beverages (congeners)

f. emotion (i.e., stress, fear, anger)

g. carbonation in beverages (speeds rate of absorption)

3. Diffusion of alcohol -

a. Alcohol is diffused in the body in proportion to the water content of the various tissues and organs, appearing in greater concentration in the blood and brain then in fat or muscle tissue.

b. Absorbed alcohol is greatly diluted by the body fluids. Thus, the alcohol in 1 ounce of whiskey at 50% strength (100 proof) will be diluted, in a man of average build, to a concentration of about 2 parts per 10,000 in the blood (0.02%). In a larger person, the BAC (blood alcohol concentration) will be proportionately less, and in a smaller person, more.

4. Significance -

a. The importance of the rate of absorption, distribution, and dilution of alcohol in the body lies in their relation to the achieved alcohol concentration in various organs, particularly the brain. After rapid intake of a large amount of alcohol that is quickly absorbed, a relatively early "high" of intoxication will occur.

b. The average-size man who drinks and absorbs 4 ounces of whiskey (50% alcohol) rapidly will have 1 1/2 ounces of alcohol in his body at the end of an hour and a BAC near to 0.07%. If he drinks 8 ounces within two hours, he will have a BAC of about 0.11%. The continued accumulation of alcohol in the organism, faster than it can be metabolized, leads to increasing degrees of intoxication.

c. Alcohol as a drug affecting the CNS belongs in a class with the barbiturates, minor tranquilizers and general anesthetics, and is commonly classified as a depressant. Its effect on the brain is biphasic: at quite low concentrations, it can serve as a stimulant of some functions (exhilaration, loss of restraint, loquaciousness) but as the concentration increases, the effect is depressant (sedative, stupor, coma).

d. Because brain alcohol concentration can rarely be measured in people, BACs are used as the standard against which performances are compared. Most people exhibit functional depression or incapacitation of BAC's of 0.10%. The majority of United States use this percentage as the criterion in determining intoxication of automobile drivers. Inefficiency in some tasks begins at much lower concentrations (0.01-0.03%). Judgment and coordination are impaired to some degree before drinking 4-5 drinks.

5. Bodily disposal of alcohol -

a. Disposal begins immediately after absorption. An insignificantly small proportion is exhaled through the lungs, and a tiny amount is excreted in sweat. A small proportion is secreted by the kidneys and will be accumulated and retained in the bladder until eliminated in the urine. By these means, 2-10% is eliminated. 90% is disposed of by metabolic processes, mainly in the liver. By the process of oxidation, the body produces heat and energy by combining alcohol with oxygen and ultimately converts the mixture to water and carbon dioxide. The oxidation process proceeds at a fairly constant rate. That is why time is one of the most important factors in eliminating alcohol from the body. Taking a cold shower or drinking coffee does allow the passage of time; neither remedy increases the rate of oxidation.

b. If one wishes to drink but avoid intoxication, beverages should be spaced one hour apart. In addition, drinks should be sipped slowly. An average person needs an hour to oxidize 1/2 oz. of alcohol which the average drink usually contains.

V. VOCABULARY/TERMINOLOGY

A. Addiction

1. Discussion of addiction might be a simple matter if the habitual compulsive use of opium was the only drug of abuse. But there are probably as many kinds of abuse as there are drugs to abuse, or, indeed as maybe there are persons who abuse.

2. Various substances are used by so many different people in so many different ways for so many different purposes that no one view or definition could possibly enhance all the considerations (med, psych, sociological, legal, etc.) that have an important bearing on addiction.

3. Drug abuse was equated with narcotic addiction until recently and this conception had some basis in fact. Addiction centered on misuse of opiates, particularly morphine and heroin, and, more recently, methadone and demerol. With the introduction of various barbiturates (sedatives, sleeping pills), tranquilizers, stimulants, new and old hallucinogens and combinations of these, the unitary consideration of addiction became untenable. Problems also arose in attempting to broaden addiction to include habituation, and finally, drug dependence.

4. Many substances act on the biological system. Whether a particular substance comes to be considered a drug depends, in large measure upon whether it is capable of eliciting a "druglike" effect valued by the user.

One can consider the drugs caffine and nicotine and the habitual, excessive use of coffee and tobacco as clearly drug dependence, if not addiction. This consideration could be extended to include tea, chocolate and sugar, substances which many of us have become dependent upon.

This frame of reference leads one to recognize that almost any substance can be considered a drug, any drug is capable of abuse,

and one kind of abuse can differ considerably from another. One can acknowledge, therefore, that drug addiction is not a unitary condition.

Before actually defining what many sources refer to as addiction and habituation, a discussion of tolerance and dependence is necessary.

B. Tolerance

1. Tolerance is defined as a physiological phenomenon that requires the individual to use more and more of the drug in repeated efforts to achieve the same effect.

2. At the cellular level, there is the diminished response to a foreign substance (drug) as a result of adaptation.

3. Opium derivitives rapidly produce a high level of tolerance, whereas alcohol and barbiturates a low level. Tolerance is characteristic for morphine and heroin and, therefore, considered a cardinal characteristic of narcotic addiction. However, tolerance for a drug may be completely independent of the drugs ability to produce physical dependence.

4. Stages of tolerance

a. 1st stage - duration of effects shrinks requiring the drug to be taken more frequently or in greater amounts to produce the desired effect.

b. 2nd stage - there is a loss of effects, both desired and undesired and finally each new level quickly reduces effects until the user arrives at a very high level of drug with a very high level of tolerance. A user may become almost completely tolerant to 5000 mg of morphine per day, when the clinical single dose to relieve pain is in the 5-20 mg range. An addict may achieve levels nearly 200 times the dose that would be dangerous for the normal, pain-free adult.

C. Physical/Psychological dependence

1. Physical dependence is defined as a state of adaptation to a drug accompanied by the development of tolerance and manifested by a withdrawal or abstinence syndrome (discussed later).

2. Psychological dependence involves feelings of satisfaction and a drive to repeated or continuous administration of the drug to produce pleasure or avoid discomfort. This mental state is a powerful factor involved in chronic use of psychotropic drugs and with some drugs psychologic dependence may be the only factor involved in intense craving and compulsive use.

D. Addiction vs. Habituation/Drug Dependence

1. The traditional distinction between "addiction" and "habituation" centers on the ability of a drug to produce tolerance and physical dependence.

2. The opiates clearly possess the potential to massively challange the body's resources causing the altered cellular response. The cells require the continued presence of the foreign substance (drug) to maintain normal function. When the substance is abruptly withdrawn, cellular function is abnormal for a time until a new readjustment is made.

3. Drugs such as caffine, nicotine, cocaine, bromide, amphetamine and other stimulants, certain tranquilizers and sedatives are normally not taken in sufficient amounts to present the challenge. They typically, but not necessarily, induce a strong need or craving emotionally or psychologically without producing the physical dependence associated with hard addiction. Their danger is, therefore, judged to be less, so that continued use would lead one to expect habituation, but not addiction. The key word is expect. When these drugs are used excessively, on occasion, they do produce tolerance and withdrawal.

4. Morphine, heroin, other synthetic opiates, and to a lesser degree codeine, alcohol and the barbiturates are potentially dangerous

for they are easily capable of presenting a bodily challenge. Therefore, they are judged to be addicting under continued use.

5. The ultimate effect of a particular drug depends on:

a) the setting
b) the expectation of the user
c) the personality of the user
d) social forces that play on the user
e) the pharmacological properties of the drug

6. Because of the enormous difficulties in trying to apply these definitions of habituation and addiction, the World Health Organization, in 1964, recommended a new term, drug dependence, to replace the earlier terms. Drug Dependence is defined as a state arising from the repeated administration of a drug on a periodic or continual basis. Its characteristics will vary with the agent involved, and this must be made clear by designating drug dependence of a particular type, e.g. of morphine type, of cannabis type, of barbiturate type, etc.

7. Tolerance and physical dependence are not prominent in this new definition, but are still conspicuously present. The emphasis, instead has shifted in the direction of the psychological makeup of the user, the pattern of use and the subculture. One must consider the concept of psychological reliance in terms of both a sense of well being, and a semi-permanent or permanent pattern of behavior. There is also the concept of gratification by chemical means, i.e. the drug has been substituted for adaptive behavior.

E. Alcoholism

1. Alcoholism is a complex phenomenon requiring more than one definition. The search for a workable, widely accepted definition continues and in order to give a sense of the direction of the search, representative definitions are presented.

2. According to the American Medical Association's Manual on Alcoholism:

"Alcoholism is an illness characterized by significant impairment that is directly associated with persistant and excessive use of alcohol. Impairment may involve physiological, psychological or social dysfunction."

3. The National Council on Alcoholism/American Medical Society on Alcoholism Committee on Definitions states:

"Alcoholism is a chronic, progressive and potentially fatal disease. It is characterized by tolerance and physical dependency, pathologic organ changes, or both, all of which are the direct consequences of the alcohol ingested."

4. Alcohol Problems, A Report to the Nation, 1967, defines the problem:

"For the purpose of this report, alcoholism is defined as a condition in which an individual has lost control over his alcohol intake in the sense that he is consistently unable to refrain from drinking or to stop drinking before getting intoxicated."

5. In Keller and McCormick, A Dictionary of Words About Alcohol, 1968, alcoholism is defined as:

"A chronic and usually progressive disease, or a symptom of an underlying psychological or physical disorder, characterized by dependence on alcohol (manifested by loss of control over drinking) for relief from psychological or physical distress or for gratification from alcohol intoxication itself, and by a consumption of alcoholic beverages sufficiently great and consistent to cause physical or mental or social or economic disability. Or, a learned (or conditioned) dependence on alcohol which irresistably activates resort to alcohol whenever a critical internal or environmental stimulus occurs."

6. A common feature of the above definitions, is a dependence on alcohol. Most importantly, alcoholism is a broad term and people may mean different things when they use it.

7. To formulate more precise definitions, the World Health Organization offers:

a. "The alcohol dependence syndrome is manifested by alterations at the behavioral, subjective, and psychobiological levels with, as a leading symptom, an impaired control over intake of the drug ethyl alcohol."

b. An alcohol-related disability is deemed to exist when there is an impairment in the physical, mental or social functioning of an individual, of such nature that it may be reasonably inferred that alcohol is part of the causal nexus determining that disability.

c. According to these definitions, the alcohol dependence syndrome is an alcohol-related disability, but not all alcohol-related disabilities reflect an alcohol dependence syndrome. Another important point is that disability occurs in varying degrees.[2]

F. Withdrawal (abstinence syndrome)

1. Physical dependence manifests itself by the signs and symptoms of abstinence when the drug is withdrawn. All levels of the CNS appear to be involved. If the addict is abruptly deprived of a drug upon which the body has physical dependence, there will ensue a set of reactions, the intensity of which will depend on the amount and length of time that the drug has been used.

2. Addiction to morphine or heroin results in the following withdrawal syndrome:

a. reaction begins within several hours of the last dose, peaking in 1-2 days.

b. initial symptoms include yawning, tears, runny nose, and perspiration.

c. sleep is restless and fitful.

d. after resting, pupils contract, hot and cold flashes occur along with gooseflesh, severe leg pains, generalized body aches and constant movement.

e. continued withdrawal produces insomnia, nausea, vomiting and diarrhea, along with a fever, mild high blood pressure, loss of appetite, dehydration, and considerable weight loss. These symptoms

continue through the third day and then decline over the next week.

f. There are variations in the withdrawal for other drugs, e.g. the barbiturates and minor tranquilizers, in which withdrawal may be more dangerous and severe.

g. During withdrawal, drug tolerance is lost rapidly and the withdrawal symdrome may be terminated at any time by an appropriate dose of the addicting drug.

3. Alcohol Withdrawal Syndrome

a. Most commonly found is the hangover.

b. After a prolonged bout of drunkeness, symptoms may consist of:

1) tremulousness
2) loss of appetite
3) inability to retain food
4) sweating
5) restlessness and sleep disturbances
6) sometimes epileptiform seizures
7) abnormal body chemistry changes, particularly in electrolyte balance

c. In extreme cases, symptoms include:

1) delerium tremens, a gross trembling of the entire body, sometimes with seizures, mental clouding, disorientation, and hallucinations, both visual and auditory. DT's last 3-10 days, depending on amount and quality of treatment with a fatality rate of 1-20%.
2) acute alcoholic hallucinosis may develop with or without preceding DT's and may last days to weeks.
3) other brain disorders may include Wernicke's disease, resulting from an acute, complete deficiency of thiamine (vitamin B1) and marked by clouding of consiousness and paralysis of the optic nerves.
4) the acute form of Korsakoff's syndrome, marked by loss of recent memory, with a tendency to make up for the defect by confabulation.
5) Jolliffe's encephalopathy, resulting from an acute complete deficiency of nicotine acid and marked by delerium, together with rigidities of the extremities and sucking and grasping reflexes.

VI. PROPOSED CAUSES OF NURSE IMPAIRMENT

A. Shift Work

1. According to Michael Rose's article in the April, 1984, AJN (pp. 442-447), schedules that violate known circadian principles can no longer be justified. Adverse effects of shiftwork include:

a. Sleep - The most common trouble shiftworkers have is the quality and quantity of sleep, which is considerable inferior to day workers sleep. The average shiftworker gets 6 hours of sleep compared to 7½ for the day worker. Shiftworkers get significantly less rapid-eye-movement (REM) sleep, the deepest sleep, and awaken more frequently then do dayworkers.

b. Physiology - Shiftworkers must work when body temperature cycles are at low levels. Timothy Monk, PhD., research psychologist at the Institute of Chronobiology, N. Y. Hospital, Cornell Medical Center states that although total variation in temperature is only about 1°F, it is still significant. "For many tasks, there is a strong parallel between the circadian rhythms of temperature and performance. Performance is held to show a steep rise from early to mid-morning, a more gradual rise to an evening peak (perhaps interrupted by a post-lunch dip), followed by a sharp decline into the [normal] hours of sleep."[3]

Monk has shown that once shiftwork interrupts the circadian rhythm of temperature, it would take 12 days before temperature and performance become synchronized again.

Other physiologic problems which affect shiftworkers more frequently are diarrhea and constipation (due to altered eating habits),ulcers, gastritis, respiratory problems, lapses in memory, back pain and nervousness. Very significant for the potential abuser.

c. Social and Family Life - Monk comments, "It is often tempting to either dismiss [family problems] as peripheral or trivialize

them. They are, however, crucial to the shiftworker's health, well-being and efficiency. In living with shiftwork, a person is already suffering (to a greater or lesser extent) from one stressor; to burden him with the additional one of social and family problems is to court emotional disaster."[4]

Free time is not easily coordinated with that of the family and/or friends, and shiftworkers often feel guilty about not spending as much time with their groups as they would like. Moreover, they tend to be irritable and tired in company. A 1979 study of U. S. hospital nurses also found that night shift nurses took significantly more sick time than afternoon shiftworkers. However, as Monk points out, generalization is not possible. "Even the most cursory investigation of shiftworkers' 'in the field' reveals wide-range individual differences, with some shiftworkers experiencing no problems at all, and others leading miserable lives, barely able to cope."

2. A Stanford Research Institute study of hospital workers found that workers on rotating shifts showed significantly higher incidences of fatigue, nervousness, and inadequate sleep when compared with fixed shiftworkers (rotation from days, evenings, nights vs. permanent 3-11 or 11-7).

3. According to Martin Moore-Ede, M.D., Ph.D, associate professor of physiology and biophysics, Harvard Medical School, "It is particularly ironic that the work schedules followed by members of the health professions - particularly house officers, nurses, and technical personnel who must care for patients around the clock -- are among the most disruptive as far as the circadian sleep-wake cycle is concerned."[5]

B. Burnout

1. For many nurses, there is no choice but to remain in their undesirable work situation because of economic difficulties. "Burnout" is a popular term used to describe the exhaustion, both mental and

physical, that nurses may experience when faced with constant tension and frustrations.

"Mental anesthesia becomes the method of survival for many nurses when their once adequate coping mechanisms are replaced by dysfunctional ones. Temporary stress-release mechanisms may allow the nurse to continue to work, but do not prevent the occurance of other, less acceptable, methods of coping. Depression and substance abuse are often the result of dysfunctional coping and will prevent the individual from rendering safe and effective care to the health care consumer. The term used to describe this syndrome is nurse impairment."[6] Behavioral tendencies in the impaired nurse include alcoholism, drug addiction, and depression resulting in lowered self-esteem, decreased work performance, and altered clinical judgment.

C. Other Predisposing Factors

1. Personal Role Adjustments

a. Tremendous emotional stress is experienced by the nursing student, whether a young high school graduate or a middle-aged person who enters nursing after years of work. Besides a demanding cirriculum, the student is faced with a feeling of isolation from family and friends not in the nursing world. Confronting terminal illness, supporting families of the sick, and coping with feelings of helplessness add to the internal role stresses the student experiences.

b. Often, these experiences do not afford the student the opportunity to work through the anger and grief experienced, and result in frustration and anxiety. Flexible coping strengths will be necessary for the individual to resolve these stresses.

2. Professional Role Adjustments

a. Positive reinforcement for the nurse is often infrequent, especially among peer groups and supervisors. Even the highly idealistic and willing to serve others individual needs to be encouraged and praised for their role in the profession. If expected rewards of gratitude are not received, the nurse tends to substitute mental notes of rejection and abandonment, resulting in negative reinforcement and lowered self-esteem.

b. Characteristically, nurses are their own worst enemies. They tend to provide poor sources of cooperation and appreciation for other nurses, being quick to criticize and complain. Eventually, the nurse questions his or her usefulness in the health care system, possibly leading to depression, frustration and anxiety, the leading characteristics of the impaired nurse.

3. The High Risk Personality/Alcoholism /Statistics

a. Dr. LeClair Bissell, a leading authority on alcoholism among health care professionals, and a recovered alcoholic herself, estimates that approximately 40,000 of our 1½ million nurses are alcoholics and an unknown number of nurses are simultaneously or independently in trouble with other drugs. She claims there is little reliable data to substantiate these figures mainly because of the stigma, the nurse's denial of the problem (a characteristic of the illness) and the fear of legal or vocational reprisals.

b. From February 1982-November 1982, the Board of Nursing in New Jersey received 159 complaints and/or requests for review of license status (approximately 70% of these for substance abuse).

The National Council of State Boards of Nursing in 1980-81 reported 971 disciplinary action cases by member boards. 67% were for substance abuse.

The Bay Area Task Force (California) reports an <u>estimated</u> national figure of 100 nurse deaths yearly due to alcohol/drug abuse. There are approximately 120,000 <u>reported</u> cases of dependency among U. S. nurses.

c. "Although Dr. Bissell has not discovered a particular personality profile among alcoholic nurses, she has found that many of them had been in the top third of their classes, obtained advanced degrees, and held demanding responsible positions in which they functioned with great competence. Ambitious, achievement-oriented nurses, they were highly respected for their excellent work, which often continued for years after they began to drink heavily, before they finally succumbed to the effects of alcoholism." [7]

d. The alcoholic nurse often compounds her drinking problem by developing drug dependency as well (more than 1/3 of the alcoholic nurses Dr. Bissell studied were hooked on both). A well-meaning colleague may give her a tranquilizer, she herself may take advantage of the access to drugs, or even a psychiatrist may prescribe a sedative to take care of her "nerves," especially if the MD is not an expert on alcoholic problems.

D. Availability of Drugs

1. The drugs most commonly abused by nurses are narcotics, non-narcotic depressants, and stimulants. These medications are usually obtained in the employment situation - hospital, clinic, physician's office, and so on, or by prescription, legal or illegal. By far, the most abused drug by nurses and the general public is alcohol. The focus will first be on the procurement of frequently abused drugs in health care facilities.

2. Diversion of medications/falsifying records - Numerous articles describe the methods by which nurses procure drugs for themselves. The following observations were taken from the Sept. 1974 AJN article written by four nurses who were former addicts. No single clue is sufficient to prove abuse but are suggestive "within the context of emotional changes noted in staff members, patient complaints, and the overall climate of a nursing unit or health care agency.

1. One nurses name consistently appears most often on controlled-drug sign-out sheets.

2. Records consistently indicate that a patient required a PRN medication the maximum number of times it could be given, but only on one nursing shift.

3. The patients of one nurse deny receiving any medication that relieved pain or helped them sleep, but medication records show that such drugs were given to them.

4. Patients ask why the medication given on one shift does not relieve their pain nor induce sleep.

5. A nurse makes many medication 'errors' that require changes or corrections in medication charting.

6. One nurse frequently reports unwitnessed drug loss through accidental breakage of containers or spilling.

7. An audit of medication records show possible irregularities. For example, where PRN-drug dose and time are prescribed subject to nursing evaluation and judgment, audit may indicate that the maximum amount of drug was administered at the greatest frequency by one nurse, but that other nurses gave smaller amounts and/or gave them less often.

8. Excessive ordering of drugs for a particular unit or ward.

9. Frequent volunteering by one nurse to give medications, especially PRN drugs.

10. Frequent 'borrowing' of medications by one unit from another.

11. One nurse often reports to work early or stays overtime for no valid reason.

12. Physical changes in the medications themselves (lighter color, cloudiness), unusual rates of use, disappearance of entire vials or bottles, or evidence that capsules or seals have been tampered with." [8]

13. Changed behavior patterns in nurses (discussed later).

E. "Risk Factors in Personal or Family Background

1. A history of alcoholism among parent, siblings, grandparents or uncles and aunts.

2. A history of teetotalism, especially if strong moral overtones are present. If an individual was raised in such a family and later encounters a situation where drinking is strongly encouraged and the individual drinks, he or she should be considered at particularly high risk.

3. Previous or existing alcoholism in the spouse or the family of the spouse.

4. Coming from a broken home or home with much parental discord.

5. Having a father who was often absent or rejecting, but not punitive.

6. Being the last child of a large family or in the last half of the sibship in a large family.

7. Being from an Irish or Scandinavian cultural background.

8. Having female relatives of more than one generation who have had a high incidence of recurrent depressions.

9. Being a heavy smoker. (Heavy drinkers are often heavy smokers; however, heavy smokers are not necessarily heavy drinkers.)"[9]

VII. COMMONLY ABUSED DRUGS IN THE NURSING PROFESSION/SIGNS & SYMPTOMS/BEHAVIOR

A. Narcotics

1. Two main emotion problems are evident in nurses who abuse narcotics: depression and anxiety.

2. Signs and symptoms include:

a. Pupil constriction - which can't be hidden unless dark glasses are worn.

b. Increased sweating and itching as evidenced by frequent scratching.

c. Drowsiness with perhaps a decreased alertness and accuracy in performing functions that require precision.

d. A relaxed, euphoric state almost immediately following obvious anxiety or depression.

e. If withdrawal starts to occur, evidence of flu-like symptoms, along with mild to moderate anxiety and subsequent acting-out behavior, such as threats, anger and feigned physical illness may be seen.

B. Non-Narcotic Depressants

1. This category includes drugs such as alcohol, barbiturates (Nembutal, Seconal, Tuinal, Phenobarbital), tranquilizers (Meprobamate, Librium, Valium), and sedatives (Doriden and Placidyl).

2. Among the many reasons nurses seek the relaxing effects of these drugs, the following are most common:

a. The tense, anxious person finds an escape from problems through deep, drugged sleep.

b. The nurse primarily abusing amphetamines and other stimulants may also use a depressant to lessen the intensity of stimulation and relieve the insomnia that stimulants may cause.

c. Alcoholics sometimes abuse depressants because they produce some of the same effects as alcohol, witnout the tell-tale odor. If the two are combined, the depressant effects are greatly intensified.

3. Symptoms (many symptoms resemble intoxication, particularly the barbiturates).

a. Poor motor coordination.
b. Slurred speech.
c. Somnolence
d. Nystagmus
e. Inability to accomplish skilled tasks (e.g. "shakes" prevent starting of IV's).
f. Confusion and impaired memory.
g. Impaired perception and judgment.
h. Extreme symptoms of agressive behavior, hallucinations, and paranoid delusions.

4. Unsupported Withdrawal Symptoms (progressive)

a. Restlessness, irritability, insomnia.
b. Increased temperature, decreased pulse pressure, and an increase in pulse rate of over 15 beats/min. when the patient stands.
c. Muscular twitching and hyperactive reflexes, coarse tremors of the hands and face.
d. Anorexia, nausea and vomiting with abdominal cramps.
e. Dilated pupils; convusions that progress to severe grand mal (with the attendant risk of death from aspiration or injury).
f. Psychosis with visual and auditory hallucinations, confusion, paranoia and delerium.
g. Treatment includes determination of drug tolerance followed by enough medication to keep symptoms to a minimum with a slow decrease in daily total dosage. Complete physical withdrawal

takes approximately 10 days, depending on type and amount of drug used and patient response.

C. Stimulants

1. Nurses do not usually have cocaine readily available to them, therefore, the most commonly used drugs are the dextroamphetamines (Dexedrine), and the methamphetamines (Desoxyn).

2. Reasons for use:

a. Fatigue - with demanding schedules, shiftwork, household duties, nurses may use stimulants to dispel weariness.

b. Emotional depression - acute or chronic personal or family problems may precipitate use of stimulants to achieve a sense of well being and self-confidence.

c. Chemical depression - the nurse who abuses alcohol or other depressants may use stimulants to counteract the hangover and "morning after" lethargy these drugs produce.

3. Signs & Symptoms

a. Hyperactive, talkative.

b. Jittery, irritable; may have continuous "chewing" movements.

c. Tries to accomplish several things at one time, and fails to complete anything.

d. Exaggerated euphoria and self-confidence observed shortly after a depressive state.

e. Impairment of memory and judgment.

f. Dilated pupils, heavy perspiration and anorexia with severe weight loss.

g. Tendency to become careless about personal hygiene and general appearance.

4. Psychological Withdrawal

a. Addiction to stimulants is primarily psychological so gradual withdrawal is not indicated.

b. Great psychological support is extremely important, as the individual may become depressed to the point of suicide.

VIII. PREVENTION OF NURSE IMPAIRMENT

A. A joint effort must be made by the profession, the health care institution and the individual if the problem of nurse impairment is to be conquered.

1. The Profession's Responsibility

a. Adjustment of the new graduate between the ideals of nursing school and the reality of the work environment should be a part of the curricula in the nursing program. Tremendous stress is encountered in the transitional process, and dialogue or role playing about a real or anticipated conflict are useful stress-reducing techniques.

b. Nursing service orientation programs should be geared to the individual needs of the graduate to make this transition from student to nurse as smooth as possible. If this does not occur, predispositon to further stress, increased frustration and possible impairment may occur.

c. Throughout their education, nurses are taught to give "total patient care" and this somehow translates into "all things to all people" attitudes. After graduation, such a "supernurse" identity cannot be related to the work situation, therefore, frustration and anxiety results because the nurse cannot implement nursing practices in the manner it was taught.

d. The exodus of nurses from the profession points out the frustration and anxieties experienced by many. The profession has an obligation to make a commitment to nurses everywhere to remain active in nursing and to take measures to provide assistance and rehabilitation for impaired nurses plus develop programs to those vulnerable. We are seeing evidence of this by the increase in workshops, seminars and articles aimed at prevention of impairment.

2. The Health Care Institute

a. The health care institute must make every effort to prevent and rehabilitate the impaired nurse. It is proven cost-effective to keep permanent staff. Estimates of replacing one staff nurse range from $1,500-3,000 with the cost of recruitment estimated at $866 per person. The aim should be focused on nonpunitive treatment plans through employee assistance programs.

3. The Nurse

a. Nurses themselves must be responsible for identifying stress factors, external and internal, that threaten their well being and predispose them to dysfunction.

b. Reactions to stress may manifest in physiological, and/or psychological manners and eventually there will be signs of actual physical disorders, e.g. colitis, MI's, asthmatic attacks or impairments such as psychosis, chronic depression or addiction. Awareness of these symptoms is a must.

c. Becoming aware of self-care strategies to prevent impairment is essential for nurses. The individual must be motivated to learn and practice these and focus on positive aspects of one's personality strengths, talents and abilities.

B. Safeguards and procedures for regulating narcotics.

1. Narcotics and other drugs that are classified as potentially drugs of abuse should be available in the unit dose that is most commonly ordered.

2. Preparation and storage areas should be locked and close observation made of these areas by all staff.

3. Close surveillance procedures for reporting controlled drugs, including verified reports of medications spilled, spoiled or wasted.

4. Observation by a second nurse when excess medication is disposed of.

5. An accounting system for non-controlled drugs with abuse potential.

6. Regulation of "borrowing" procedures:
   a.) written records of the drug and amount transferred
   b.) date, time and signatures of nurses involved.

7. Accurate counting of controlled drugs at the beginning and end of each shift by oncoming and outgoing nurses.

C. Other Strategies

1. Development of a workable plan for dealing with prevention of impairment.

2. Exploration of individual and collective knowledge and attitudes concerning drug abuse among the staff.

3. Development of an understanding of drug abuse as an indication of severe underlying emotional problems.

4. Discussion of how the troubled nurse can be helped.

5. Investigation of the legal implications for the nurse and employer.

6. Focus on prevention: provide education for nursing faculty, supervisors and staff in recognizing stress among employees and working with troubled persons.

D. Recogniton of Stress

1. Handout of Stress Worksheets
2. Small group study
3. Summation of results

IX. INTERVENTION

A. Recognition of the Problem (Review)

1. Job Performance:
   a.) frequent absenteeism
   b.) frequent disappearance from unit
   c.) job shrinkage (minimal work)
   d.) inability to meet schedules
   e.) illegal or sloppy charting
   f.) excessive errors - medication spillage, incorrect narcotic count, errors of judgment in patient care decisions.

2. Non-specific changes:
   a.) personality changes, mood swings, irritability followed by euphoria.
   b.) increasingly isolationist behavior; avoidance of staff parties; lunching alone; decrease in outside activities.
   c.) inappropriate responses, unkempt appearance, elaborate behavioral excuses.
   d.) forgetfulness, loss of memory (blackouts), decreased alertness.

3. Alcoholism clues:
   a.) frequent "soda" breaks and use of breath deodorants.
   b.) alcoholic breath, flushed face, unsteady gait, reddened or bleary eyes, slurred speech.
   c.) physical problems associated with alcohol abuse; jaundice, ascites, spider veins (liver damage),cigarette burns, bruises, gastritis.

4. Drug addiction clues:
   a.) physical signs of withdrawal.
   b.) defensive behavior when questioned re medication.

c.) waiting to be alone to open narcotics.

d.) frequently volunteering to be the med nurse or offering to give PRN's.

e.) frequently disappears after being in the narcotic cabinet.

f.) has numerous patients who complain of ineffective pain medications.

B. Intervention Plan

1. Severe stress may cause an individual to react with many of the symptoms described in the impaired nurse. The focus should be on job performance. If you are staff personnel, report your observations to the nursing supervisor. The following steps toward intervention are offered when the problem is acute:

a. Note the behavior. Observe signs objectively, not judgmentally. Document slurred speech, evidence of errors in judgment, uncontrollable anger, poor coordination. Have a second person present to validate observations.

b. Remove the nurse from the situation and, in private, confront him/her with the behavior observed. Be firm, not critical or judgmental. Explain briefly, decisively, and unemotionally to the employee that you are placing him/her on personal leave because it is your observation that he/she is too impaired to perform duties safely and effectively. Any extended discussion while the person is intoxicated is useless. Plan to meet within 24 hours at a specific place and time.

c. If the nurse is incapacitated, send him/her home or to a place to rest and recuperate. If necessary, get a friend, relative or co-worker to transport the nurse; avoid having the impaired individual drive.

d. Document for the record. Describe <u>behavior</u> objectively, stating course of events before, during, and after the confrontation.

State the action taken, including where you sent the nurse and with whom, and note employee meeting date. The employee should sign and date this memo and receive a copy. Refusal to sign should be noted.

e. Inform the immediate supervisor of the incident ASAP.

2. When the problem is one of a chronic nature, e.g. occuring over a period of time, it is critical to document behavior precisely, including dates and times. Other strategies include the following.

a. Set a specific time and date for a conference.
b. Present specific data and observations related to the incident(s) and explain how these affected job performance or patient care.
c. Listen to the nurse's explanation.
d. Identify available choices for correcting the behavior.
e. Make an agreement that stipulates behavioral criteria and a specific time frame for improvement. Make it clear that performance must improve.
f. State all terms for continuing or returning to employment.
g. Give a written copy of the terms to the nurse.
h. Let the nurse know you will be glad to assist in appropriate ways.
i. If referrals are made, it is the nurse's responsibility to comply.
j. Let the nurse know you will provide continued support, but the only thing that can be monitored is job performance, not the nurse's compliance or non-compliance with treatment.
k. Remember, you are not the nurse's counselor. Encourage other sources of support. You cannot be all things to him/her. It is unfair to both parties.
l. Nurses' first obligation is protection of the patient from potential hazards. Any suspected problem should be reported immediately.

C. A List of Dont's

The following list reflects what one should not do, under any circumstances, when dealing with the impaired nurse.

"1. Don't lecture, moralize, scold, blame, threaten, or argue with the person about the problem. Document it and use it to counsel the person about job performance.
2. Don't lost your temper.
3. Don't enable the problem to continue by covering up the consequences, trying to protect, making excuses, or doing his/her job.
4. Don't give the person an easier work schedule.
5. Don't have a holier-than-thou attitude.
6. Don't be overly sympathetic. You are not a counselor or a big brother/sister.
7. Don't accept what you know is a lie. When you know the nurse is lying, say so. Accepting lies only encourages more lying, and you will lose his/her respect at the same time.
8. Don't accept mere promises to 'do better,' and don't keep switching agreements. When you say that a job is in jeopardy (suspension or termination) if performance does not improve, you must follow through.
9. Don't accept the responsibility of letting someone work on your unit or team if impaired by alcohol or drugs. Judgment is the first to go.
10. Don't put off facing the problem, hoping it will get better with time. It won't."[10]

D. Employee Assistance Programs

Many companies and health care institutes have developed EAP's. The goals are to offer assistance to those employees whose performance has shown a decline and who have shown significant changes in their work patterns.

E. Community Resources

1. Self Help Groups

a.) Alcoholics Anonymous

b.) Narcotics Anonymous

c.) Pills Anonymous

In NJ d.) Nurses Concerned for Nurses & N.J.

e.) Nurses CARE (Committee on Addiction, Rehabilitation & Education)

2. Hot Lines/Treatment Centers

Find assistance in the local telephone directories under Mental Health Services and Clinics.

3. Governmental Agencies

a.) State Board of Nursing

b.) State Health Department

c.) Federal: U. S. Dept.of Health, Education & Welfare
Public Health Service
Alcohol, Drug Abuse & Mental Health Administration
Rockville, Maryland 20857

X. LEGAL/ETHICAL IMPLICATIONS

A. Loss of license/penalties

1. A hearing before the state board of nursing may result in permanent or temporary revocation of a nurse's license.

2. The following statistics cover the 9 month period of Feb. 1982 - Nov. 1982 in which the N. J. Board of Nursing received complaints and/or requests for review of license status.

Total of complaints	= 159	(approximately 70% due to substance abuse)
Revocations	7	
Suspensions	22	
Fines	8	
Probation	6	
Reinstatements	7	
Dismissed	44	(including 1 drug-related death of the nurse involved)
Pending hearing/ investigation	63	

B. Loss of Employment

1. Removal of the employee may be temporary or permanent.

2. In acute cases, employment is usually suspended indefinitely pending treatment.

3. The trend seems to favor non-punitive type action in which the employee is offered choices of treatment which are mandatory if the employee expects to return to work.

4. If the employee is non-compliant, termination of employment usually occurs.

XI. SUMMATION

The incidence of nurse impairment is a growing problem which must be addressed by the profession, the health care institutes, nurse educators, and nurses themselves. Sharing the responsibility for dealing with the problem seems to provide the best solution available. The development of seminars, workshops, educational curricula, in-service programs and an increased awareness of the problem is essential.

The impact of nurse impairment is far reaching. It affects all relationships; nurse-patient; professional; personal. Each and every one of us must reach out to prevent or help in some way to reduce the number of impaired nurses.

END NOTES

[1] "Drug Problems," Encyclopedia Britannica, Vol. 5 (1983), p. 1049.

[2] The Community Health Nurse and Alcohol-Related Problems, (Rockville, Md.: U. S. Dept. of H.E.W., National Institute on Alcohol Abuse and Alcoholism, 1978), pp. 2-3.

[3] Michael Rose, "Shiftwork: How Does it Affect You," American Journal of Nursing, Vol. 84, No. 4 (April, 1984), pp. 443-444.

[4] Ibid.

[5] Ibid., p. 447.

[6] T. Audean Duespohl, Nursing in Transition (Rockville, Md.: Aspen Publications, 1983), p. 213.

[7] Charlotte Isler, "The Alcoholic Nurse: What We Try to Deny," R N, (July, 1978), pp. 48-55.

[8] Elaine B., Clare M., June S., Janet A., "Helping the Nurse Who Misuses Drugs," American Journal of Nursing, Vol. 74, No. 9 (September, 1974), p. 1667.

[9] C. L. Whitfield and K. Williams, "The Patient with Alcoholism and Other Drug Problems," The Community Health Nurse and Alcohol Related Problems (Rockville, Md., 1978), p. 10.

[10] Linda Jefferson and Barbara E. Ensor, "Help for the Helper: Confronting a Chemically-Impaired Colleague," American Journal of Nursing, Vol. 82, No. 4 (April, 1982), p. 577.

REFERENCES

Bissel, Le Clair & Jones, Robert W., "The Alcoholic Nurse," Nursing Outlook, February, 1981, pp. 96-101.

Disciplinary Action Summary, State of New Jersey, Department of Law and Public Safety, Division of Consumer Affairs, Board of Nursing, Newark, N. J., 1983.

Duespohl, T. Audean, Nursing in Transition, (Rockville, Md.: Aspen Publications, 1983)

Elaine B., Clare M., June S., Janet A., "Helping the Nurse Who Misuses Drugs," American Journal of Nursing, Vol. 74, No. 9, September, 1974, pp. 1665-1671.

Encyclopaedia Britannica, "Alcohol Consumption," Volume 1, (Chicago, Ill.: Encyclopaedia Britannica, 1983) pp. 437-450.

Encyclopaedia Britannica, "Drug Problems," Volume 5, (Chicago, Ill.: Encyclopaedia Britannica, 1983), pp. 1048-1060.

Isler, Charlotte, "The Alcoholic Nurse: What We Try to Deny, " RN, July, 1978, pp. 48-55.

Jefferson, Linda V. & Ensor, Barbara E., "Help for the Helper: Confronting a Chemically-Impaired Colleague," American Journal of Nursing," Vol. 82, No. 4, April, 1982, pp. 574-577.

Oss, James N., et al, Clinical Management of Drug Abuse Crisis: A Reference Manual for Health Professionals, (Nutley, N. J.: Hoffman-LaRoche, Inc., 1973).

Rose, Michael, "Shiftwork: How Does it Affect You," American Journal of Nursing, Vol. 84, No. 4, April, 1984, pp. 442-447.

Schmalenkerg, Claudia & Kramer, Marlene, "Bicultural Training: A Cost Effective Program," Journal of Nursing Administration, December 1979, p. 10.

Stepter, Nancy Rufli, "Drug Abuse Among Nurses," Nursing Management, December, 1982, pp. 41-43.

Survive and Thrive: An NJEA Guide to Beating Burnout, New Jersey Education Associates, Trenton, N. J.

The Community Health Nurse and Alcohol-Related Problems, U. S. Department of HEW, National Institute on Alcohol Abuse and Alcoholism, Rockville, Md., 1978.

SELECTED BIBLIOGRAPHY

"Alcoholism, Addiction, Depression: A Nurse's Story," Nursing Outlook, November, 1965, pp. 48-49.

Bissel, LeClair & Jones, R. W., "The Alcoholic Nurse," Nursing Outlook, Volume 29, No. 2, February 1981, pp. 96-101.

Block, Marvin, "Alcoholism is Many Illnesses," Nursing Outlook, November, 1965, pp. 35-37.

Blose, Irwin, "Confronting the Alcoholic Employee," American Operating Room Nurse Journal, Volume 25, No. 6, May, 1977, pp. 1159-1166.

Canfield, T., "Drug Addiction of Health Professionals," American Operating Room Nurse Journal, Volume 24, No. 4, October 1976, pp. 675-671.

Cronin-Stubbs, D. & Velsor-Friedrich, B., "Professional and Personal Stress: A Survey," Nursing Leadership, Volume 4, No. 1, March 1981, pp. 19-26.

Darity, M., "Drugs: Facing Up to a Problem on Your Staff," RN, November 1979, pp. 21-26.

Disciplinary Action Summary, State of New Jersey, Department of Law and Public Safety, Division of Consumer Affairs, Board of Nursing, Newark, N. J., 1983.

Duespohl, T. Audean, Nursing in Transition, (Rockville, Md.: Aspen Publications, 1983).

Elaine B., Claire M., June S., & Janet A., "Helping the Nurse Who Misuses Drugs," Amerian Journal of Nursing, Volume 74, No. 9, September 1974, pp. 1665-1671

Encyclopaedia Britannica, "Alcohol Consumption," Volume 1, (Chicago, Ill.: Encyclopaedia Britannica, 1983) pp. 437-450.

Encyclopaedia Britannica, "Drug Problems," Volume 5, (Chicago, Ill.: Encyclopaedia Britannica, 1983), pp. 1048-1060.

Ensor, B. E., Dilday, R. C., Harakal, B. M., Heins, M., Bowman, R. A., "What the SNAs Are Doing...," American Jornal of Nursing, April, 1982, pp. 581-584.

Felt, J. K., "Legal Implications and Sanctions Respecting Impaired Health Care Professionals," presented in Detroit, March 5, 1982.

Fernau, D. W. Jr. & Morton, E. L., "Nursing Personnel and Alcoholism," Nursing Research, March-April, 1968, pp. 174-177.

Fulton, K., "Drug Abuse Among Nurses: What Nursing Management Can Do," Supervisor Nurse, January 1981, pp. 18-20.

Garb, Solomon, "Narcotic Addiction in Nurses and Doctors," Nursing Outlook, November 1965, pp. 30-34.

Greenlaw, J., "Enforcing Professional Standards," Nursing Law and Ethics, December 1980, pages 3 & 7.

Hendrickson, J. E., "The Alcoholic Employee: How the Nurse Can Help," Nursing 75, December 1975, pp. 49-50.

Isler, C., "The Alcoholic Nurse: What We Try to Deny," RN, June 1978, pp. 48-55.

Jackson, George, Diaz,Lazara, Wallman, Geraldine, "An Employee Alcoholism Program for Nurses and Social Workers," Labor Management Alcoholism Journal, November-December, 1979, pp. 115-122.

Jefferson, L. V., Ensor, B. E., "Confronting a Chemically-Impaired Colleague," American Journal of Nursing, Vol. 82, No. 4, April 1982, pp. 574-577.

Jones, Ann, "My Birthday is Not the day I Was Born," American Journal of Nursing, July 1967, pp. 1434-1438.

Jones, J. W., "Additudinal Correlates of Employee Theft of Drugs & Hospital Supplies Among Nursing Personnel, " Nursing Research, Volume 30, No. 6, November/December 1981, pp. 349-351.

Kolesar, G., "It Could Happen to You," The Canadian Nurse, November 1980, pp. 20-23.

"Leadership at Work: When a Colleague's Drinking Becomes Your Headache," RN, July 1978, pp. 31-34.

Levenstein, A., "Alcohol and Tension," Supervisor Nurse, November 1980, pp. 46-47.

Levine, D., Preston, P., Lipscomb, S. & Ross, W. F., "A Special Program for Nurse Addicts," American Journal of Nursing, Volume 74, No. 9, September 1974, pp. 1672-1673.

Levine, D., Preston, P. & Lipscomb, S., "A Historical Approach to Understanding Drug Abuse Among Nurses," American Journal of Psychology, Volume 131, No. 9, September 1974, pp. 1036-1037.

Naegle, M., "Confronting the Impairment Problem: Current Approaches to Identification and Treatment," including bibliography, Presented in Detroit, March 5, 1982.

Oss, James N. et al, Clinical Management of Drug Abuse Crisis: A Reference Manual for Health Professionals, (Nutley, N. J.: Hoffman-LaRoche, Inc., 1973).

Pierce, S., "When the Addict is a Nurse," American Operating Room Nurse Journal, Volume 24, No. 4, October 1976, pp. 655-664.

Poplar, Jimmie, "Characteristics of Nurse Addicts," American Journal of Nursing, January 1969, pp. 117-119.

Regan Report, "Drug Abuse by RN's: Unprofessional Conduct?"

Rose, Michael, "Shiftwork: How Does it Affect You," American Journal of Nursing, Vol. 84, No. 4, April 1984, pp. 442-447.

Schmalenkerg, Claudia & Kramer, Marlene, "Bicultural Training: A Cost Effective Program," Journal of Nursing Administration, December 1979, p. 10.

Schnurr, S., "The Alcoholic Professional," FCH, 1979, pp. 33-59.

Stepter, Nancy Rufli, "Drug Abuse Among Nurses," Nursing Management, December, 1982, pp. 41-43.

Survive and Thrive: An NJEA Guide to Beating Burnout, New Jersey Education Associates, Trenton, N. J.

The Community Health Nurse and Alcohol-Related Problems, U. S. Department of HEW, National Institute on Alcohol Abuse and Alcoholism, Rockville, Md., 1978.